

**ProAssurance**

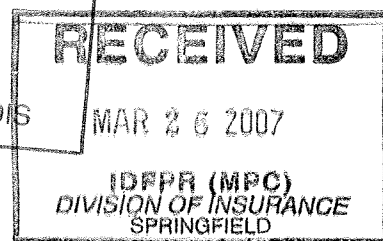
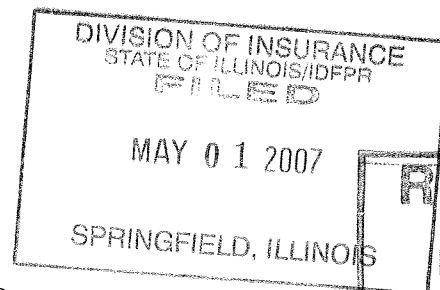


March 22, 2007

Ms. Gayle Neuman  
Illinois Department of Insurance  
320 West Washington Street  
Springfield, IL 62767

**ProNational Insurance Company**

800/282-6242  
Fax 205/802-4775



RE: ProNational Insurance Company  
FEIN # 38-2317569  
Health Care Professionals Underwriting Manual (Physicians, Surgeons, Dentists,  
Podiatrists and Allied Health Professionals  
Filing # IL0507R  
Line 11 – Medical Malpractice

Dear Ms. Neuman:

I submit for your review and approval revisions to the captioned manual. I request the effective date of May 1, 2007 for this filing submission. This filing amends the underwriting manual previously approved under Company Filing Number IL0107.

As required by 215 IL CS 5/155.18, ProNational is currently offering the quarterly payment plan. However, as a benefit to our insureds, for those that choose payment in full prior to the policy effective date, a discount of 1.5% of the policy premium is being offered.

We are also clarifying some items throughout the underwriting manual associated with tail calculation. The previous manual stated that the tail rate is calculated based on the mature claims-made annual rate in effect at policy issuance and has been modified in the state exceptions to clarify the calculation of the mature tail rate for changes in practice specialty or changes in rating territory. The wording for applicable credits has also been changed to match other sections of the manual.

I have enclosed the manual pages with marked revisions and the final version of the manual. I believe you will find everything in order. If not, please contact me at (800) 282-6242, ext. 4426 or e-mail me at [lgoodwin@proassurance.com](mailto:lgoodwin@proassurance.com).

Sincerely,

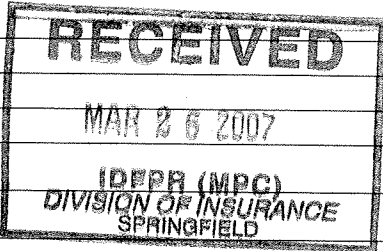
LaQuita B. Goodwin  
Compliance Specialist

Enclosures



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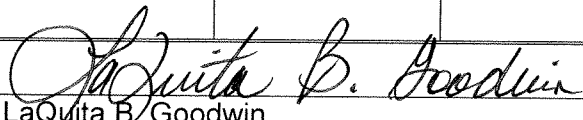
## Property &amp; Casualty Transmittal Document (Revised 1/1/06)

<b>1. Reserved for Insurance Dept. Use Only</b>	<b>2. Insurance Department Use only</b>	
	a. Date the filing is received:	
	b. Analyst:	
	c. Disposition:	
	d. Date of disposition of the filing:	
	e. Effective date of filing:	
	New Business	
	Renewal Business	
	f. State Filing #:	
	g. SERFF Filing #:	
h. Subject Codes		

<b>3. Group Name</b>	<b>Group NAIC #</b>		
ProAssurance Group	2698		
<b>4. Company Name(s)</b>	<b>Domicile</b>	<b>NAIC #</b>	<b>FEIN #</b>
ProNational Insurance Company	Michigan	38954	38-2317569

<b>5. Company Tracking Number</b>	<b>IL0507R</b>
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**Contact Info of Filer(s) or Corporate Officer(s)** [include toll-free number]

<b>6. Name and address</b>	<b>Title</b>	<b>Telephone #s</b>	<b>FAX #</b>	<b>e-mail</b>
LaQuita B. Goodwin 100 Brookwood Place Birmingham, AL 35209	Compliance Specialist	205-877-4426	205-414-2887	<a href="mailto:lgoodwin@proassurance.com">lgoodwin@proassurance.com</a>
7. Signature of authorized filer				
8. Please print name of authorized filer		LaQuita B. Goodwin		

**Filing information** (see General Instructions for descriptions of these fields)

<b>9. Type of Insurance (TOI)</b>	Medical Malpractice
<b>10. Sub-Type of Insurance (Sub-TOI)</b>	11.1 – Claims Made Only
<b>11. State Specific Product code(s)(if applicable)[See State Specific Requirements]</b>	
<b>12. Company Program Title (Marketing title)</b>	Health Care Professionals Liability Underwriting Manual
<b>13. Filing Type</b>	<input type="checkbox"/> Rate/Loss Cost <input checked="" type="checkbox"/> Rules <input type="checkbox"/> Rates/Rules <input type="checkbox"/> Forms <input type="checkbox"/> Combination Rates/Rules/Forms <input type="checkbox"/> Withdrawal <input type="checkbox"/> Other (give description)
<b>14. Effective Date(s) Requested</b>	New: May 1, 2007      Renewal: May 1, 2007
<b>15. Reference Filing?</b>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>16. Reference Organization (if applicable)</b>	
<b>17. Reference Organization # &amp; Title</b>	
<b>18. Company's Date of Filing</b>	March 22, 2007
<b>19. Status of filing in domicile</b>	<input type="checkbox"/> Not Filed <input type="checkbox"/> Pending <input checked="" type="checkbox"/> Authorized <input type="checkbox"/> Disapproved

Proper & Casualty Transmittal Document

20. This filing transmittal is part of Company Tracking # IL0507R

21. Filing Description [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]

I submit for your review and approval revisions to the captioned manual. I request the effective date of May 1, 2007 for this filing submission. This filing amends the underwriting manual previously approved under Company Filing Number IL0107.

As required by 215 IL CS 5/155.18, ProNational is currently offering the quarterly payment plan. However, as a benefit to our insureds, for those that choose payment in full, a discount of 1.5% of the policy premium is being offered.

We are also clarifying some items throughout the underwriting manual associated with tail calculation. The previous manual state that the tail rate is calculated based on the mature claims-made annual rate in effect at policy issuance and has been replaced in the state exceptions to explain how to calculate the mature tail rate for changes in practice specialty or changes in rating territory. The wording for applicable credits has also been changed to match other sections of the manual.

I have enclosed the manual pages with marked revisions and the final version of the manual. I believe you will find everything in order. If not, please contact me at (800) 282-6242, ext. 4426 or e-mail me at [lgoodwin@proassurance.com](mailto:lgoodwin@proassurance.com).

22.	<b>Filing Fees</b> (Filer must provide check # and fee amount if applicable) [If a state requires you to show how you calculated your filing fees, place that calculation below]
<div>Check #: None Amount:</div> <div>Refer to each state’s checklist for additional state specific requirements or instructions on calculating fees.</div>	

\*\*\*Refer to the each state’s checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)  
PC TD-1 pg 2 of 2

STATE/RULE FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes rate-related items such as Rate; Rule; Rate & Rule; Reference; Loss Cost; Loss Cost & Rule or Rate, etc.)

(Do not refer to the body of the filing for the component/exhibit listing, unless allowed by state.)

1.	This filing transmittal is part of Company Tracking #	IL0507R
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2.	This filing corresponds to form filing number (Company tracking number of form filing, if applicable)	
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☐ Rate Increase      ☐ Rate Decrease      ☐ Rate Neutral (0%)

3.	Filing Method (Prior Approval, File & Use, Flex Band, etc.)	File & Use
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4a.	Rate Change by Company (As Proposed)					
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Company Name	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change (where required)	Minimum % Change (where required)
No Rate Change						

4b.	Rate Change by Company (As Accepted) For State Use Only					
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Company Name	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change	Minimum % Change

5. Overall Rate Information (Complete for Multiple Company Filings only)			
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		COMPANY USE	STATE USE
5a	Overall percentage rate impact for this filing		
5b	Effect of Rate Filing – Written premium change for this program		
5c	Effect of Rate Filing – Number of policyholders affected		

6.	Overall percentage of last rate revision	-6.0%
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7.	Effective Date of last rate revision	1/1/2007
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8.	Filing Method of Last filing (Prior Approval, File & Use, Flex Band, etc.)	File & Use
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9.	Rule # or Page # Submitted for Review	Replacement or withdrawn?	Previous state filing number, if required by state
01	Pages 42, 43, 64, 67, 71, 72, 73, 74 and 77	<input type="checkbox"/> New <input checked="" type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	Company Filing Number IL0107 effective 1/1/2007
02		<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	
03		<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	

**Neuman, Gayle**

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**From:** Goodwin, LaQuita [LGoodwin@proassurance.com]  
**Sent:** Thursday, May 24, 2007 1:25 PM  
**To:** Neuman, Gayle  
**Subject:** RE: Health Care Professionals - Rule Filing #IL0507R  
**Attachments:** Page 77.PDF

Ms. Neuman,

Please find the following responses to your concerns.

1. ProNational has its own plan for the gathering of medical liability statistics. We do not use a statistical agency.
2. This is a rule filing, not a rate filing. The most recent rate filing, File # IL0107, effective January 1, 2007, was certified pursuant to 215 ILCS 5/155.18.
3. The Annual Premium Payment Discount was inadvertently omitted from Section 11 of the manual. Please find attached revised Page 77.

I believe you'll find everything in order. If you have any further questions, please let me know. Thanks.

LaQuita B. Goodwin  
Compliance Specialist  
Legal Department  
ProAssurance Professional Liability Group  
Medical Assurance/ProNational/NCRIC/PIC WISCONSIN  
Woodbrook Casualty/Red Mountain Casualty  
Birmingham, Alabama  
(205) 877-4426 or (800) 282-6242, ext. 4426 Fax (205) 414-2887

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**From:** Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]  
**Sent:** Thursday, May 24, 2007 11:21 AM  
**To:** Goodwin, LaQuita  
**Subject:** Health Care Professionals - Rule Filing #IL0507R

Ms. Goodwin,

We are in receipt of the above referenced filing submitted by your letter dated March 22, 2007. Please address the following questions/concerns:

1. Please indicate if your company has a plan for the gathering of statistics or the reporting of statistics to statistical agencies? If yes, what stat agency is being used?
2. 215 ILCS 5/155.18 states it shall be certified in this filing by an officer of the company and a qualified actuary that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience.

5/24/2007

3. The section regarding the "Annual Premium Payment Discount" was not included in Section 11 of the manual. Was this addition left out in error?

We request receipt of your response by May 31, 2007.

Gayle Neuman  
Property & Casualty Compliance, Division of Insurance  
Illinois Department of Financial & Professional Regulation  
(217) 524-6497

Please refer to the Property and Casualty Review Requirement Checklists before submitting any filing. The checklists can be accessed through the Department's website (<http://www.idfpr.com/>) by clicking on: Insurance; Industry; Regulatory; IS3 Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

THIS MESSAGE IS INTENDED FOR THE SOLE USE OF THE ADDRESSEE AND MAY BE CONFIDENTIAL, PRIVILEGED AND EXEMPT FROM DISCLOSURE UNDER APPLICABLE LAWS. IF YOU RECEIVE THIS MESSAGE IN ERROR, PLEASE DESTROY IT AND NOTIFY US BY SENDING AN E-MAIL TO:  
[Gayle.Neuman@illinois.gov](mailto:Gayle.Neuman@illinois.gov)

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I. STATE EXCEPTIONS

A. Policy Issuance

B. Rules

- 1. Item X, Amelioration, of Section 3, Classification and/or Rating Modifications and Procedures, is hereby deleted.
- 2. Item C. Reporting Endorsement Coverage of Section 3, Classification and/or Rating Modifications and Procedures, part VIII. Rate Adjustments for Changes in Exposure -- Claims-Made, Retroactive, and Reporting Endorsement Coverage, is replaced by:

The calculations for changes in exposure are performed by weighting the mature claims-made annual rates in effect at policy issuance for each period of differing exposures. These calculations are appropriate for changes in practice specialty or changes in rating territory that would affect a calculated rate. This method can be generalized by using the following weights and formula to calculate a rate for the upcoming year.

Number of years policy written	Claims-Made Year				
	1	2	3	4	5+
1	100%				
2	50%	50%			
3	37.5%	37.5%	25%		
4	33 1/3%	33 1/3%	22 2/9%	11 1/9%	
5+	30%	30%	20%	10%	10%

- 1. Mature claims-made annual rate in effect at policy issuance for the current practice and territory times the sum of the weights for the claims-made years in effect.
- 2. Plus mature claims-made annual rate in effect at policy issuance for the prior practice and territory times the sum of the weights for the claims-made years in effect.

For example, if a physician had practiced obstetrics and gynecology for over five years, then stopped practicing obstetrics and began to practice gynecology at the renewal two years prior to the electing the Reporting Endorsement Coverage, the appropriate base premium for the upcoming policy period would be:

Gynecology mature claims-made annual rate in effect at policy issuance times (30% + 30%),  
plus OB/GYN mature claims-made annual rate in effect at policy issuance times (20% + 10 % + 10%)

This method is applied in a similar manner if more than one practice change occurred during the previous four years. The components are pro-rated if the change occurred at a date other than the policy anniversary date.

**Manual Pages with Marked Revisions**



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*****		
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Deleted: 44

Deleted: 45 - 67

Deleted: 68 – 72

Deleted: 73 – 78

II. STATE EXCEPTIONS

A. Policy Issuance

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<u>1</u>	<u>100%</u>				
<u>2</u>	<u>50%</u>	<u>50%</u>			
<u>3</u>	<u>37.5%</u>	<u>37.5%</u>	<u>25%</u>		
<u>4</u>	<u>33 1/3%</u>	<u>33 1/3%</u>	<u>22 2/9%</u>	<u>11 1/9%</u>	
<u>5+</u>	<u>30%</u>	<u>30%</u>	<u>20%</u>	<u>10%</u>	<u>10%</u>

1. Mature claims-made annual rate in effect at policy issuance for the current practice and territory times the sum of the weights for the claims-made years in effect.

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This method is applied in a similar manner if more than one practice change occurred during the previous four years. The components are pro-rated if the change occurred at a date other than the policy anniversary date.

3. Section 4, Professional Liability Discounts, is hereby amended by adding the following:

**VIII. ANNUAL PREMIUM PAYMENT DISCOUNT**

A discount of 1.5% of the policy premium will be applied if the insured pays the premium in full prior to the inception date of the policy. This discount is not available if the initial policy term is less than six months. If the full premium is not received by the Company by the policy effective date, the discount will be withdrawn, the policy will be rated without the discount and the insured will be billed for the additional premium.

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The calculations for changes in exposure are performed by weighting the mature claims-made annual rates in effect at policy issuance for each period of differing exposures. These calculations are appropriate for changes in practice specialty or changes in rating territory that would affect a calculated rate. This method can be generalized by using the following weights and formula to calculate a rate for the upcoming year.

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This method is applied in a similar manner if more than one practice change occurred during the previous four years. The components are pro-rated if the change occurred at a date other than the policy anniversary date.

4. Item X, Rate Change Amelioration, of Section 3, Classification and/or Rating Modifications and Procedures, is hereby deleted.

Deleted: 4

Group aggregate deductible discounts apply to \$1M/\$3M premiums only. The applicable Deductible Discount will not change during the policy term despite changes in the number of insureds, but will be limited by any applicable maximum credit amount.

Indemnity Deductible Per Claim/Aggregate (\$000)	Number of Insureds				Maximum Credit
	2 - 19	20 - 40	41 - 60	61 - 100	
5/15	.020	.018	.015	.012	\$ 10,500
10/30	.038	.035	.030	.024	21,000
25/75	.084	.079	.070	.058	52,500
50/150	.145	.139	.127	.109	105,000
100/300	.234	.228	.216	.196	210,000
200/600	.348	.346	.338	.321	420,000
250/750	.385	.385	.381	.368	525,000

Indemnity & ALAE Deductible					
Per Claim/Aggregate (\$000)	Number of Insureds				Maximum Credit
	2 - 19	20 - 40	41 - 60	61 - 100	
5/15	.029	.026	.021	.017	\$ 12,750
10/30	.068	.063	.054	.043	25,500
25/75	.119	.112	.099	.082	63,750
50/150	.186	.179	.163	.140	127,500
100/300	.258	.252	.239	.216	255,000
200/600	.396	.394	.385	.366	510,000
250/750	.467	.467	.462	.446	637,500

7. Section 4, Professional Liability Discounts, is hereby amended by adding the following:

**VIII. ANNUAL PREMIUM PAYMENT DISCOUNT**

A discount of 1.5% of the policy premium will be applied if the insured pays the premium in full prior to the inception date of the policy. This discount is not available if the initial policy term is less than six months. If the full premium is not received by the Company by the policy effective date, the discount will be withdrawn, the policy will be rated without the discount and the insured will be billed for the additional premium.

I. RATES

A. Per Patient Rates – Emergency Room / Urgent Care

1. Rating of Emergency Room and Urgent Care Groups may, at the Company’s option be rated on a per 100 patient visit basis. A risk with fewer than 10,000 patient encounters each year will not qualify for this rating method.
2. For risks rated on a per patient basis, develop premium using the following per100 patient visit rates. The above rates are subject to increased limit factors and standard CorpCare™ rating factors.

Claims-made Rate Per 100 Patient Visits \$1,000,000 / \$3,000,000						
Class	Code	Territory 1	Territory 2	Territory 3	Territory 4	Territory 5
Emergency Room	80429	\$2,287	\$1,613	\$1,298	\$1,950	\$2,062
Urgent Care	80424(V)	\$1,725	\$1,220	\$984	\$1,472	\$1,557

3. Extended Reporting Endorsement Period Endorsement (Tail Coverage)

Extended Reporting Period (Tail) Factors  
By Month

Claims-Made  
Year

	1	2	3	4	5	6	7	8	9	10	11	12
1	0.150	0.230	0.310	0.380	0.450	0.520	0.590	0.660	0.730	0.800	0.870	0.940
2	1.010	1.080	1.150	1.220	1.280	1.340	1.400	1.460	1.520	1.580	1.640	1.700
3	1.730	1.760	1.790	1.820	1.850	1.880	1.900	1.920	1.940	1.960	1.980	2.000
4	2.030	2.067	2.100	2.133	2.167	2.200	2.233	2.267	2.300	2.333	2.367	2.400
5	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400

Example: An insured who has a third year claims-made policy and decides to cancel after three months have elapsed would purchase tail coverage at the year 3, three month factor (1.790), times the mature claims-made annual rate in effect at policy issuance. For claims-made year 5 and over the 2.400 factor applies.

Reporting Endorsement ("Tail") Premium Development

- a. Determine the tail premium for each current scheduled health care provider, if applicable. See Section 9, State Rates and Exceptions - Physicians, Surgeons and Podiatrists - Extended Reporting Period Endorsement (Tail Coverage). The only credits/discounts that apply are the Part-Time discount and Deductible credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.

**Deleted:** Deductibles and risk management credits are not applicable

- b. For per patient rated risks, use average number of patient visits for the previous thirty-six months. The only credit/discount that applies is the Deductible credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.
- c. Determine the remaining optional separate limit premium, if applicable.
- d. Add premiums determined in Steps a., b. and c. to determine total policy premium.

**Deleted:** Deductibles and risk management credits are not applicable

**B. Rating Territories**

Territory	County
1	Cook, Madison, St. Clair and Will Counties
2	Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson, Kankakee, Macon, Randolph, Washington and Williamson Counties
3	Remainder of State
4	DuPage, Kane, Lake, McHenry and Sangamon Counties
5	Jackson and Vermilion Counties

II. STATE EXCEPTIONS

A. Policy Issuance

B. Rules

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	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5+</u>
<u>1</u>	<u>100%</u>				
<u>2</u>	<u>50%</u>	<u>50%</u>			
<u>3</u>	<u>37.5%</u>	<u>37.5%</u>	<u>25%</u>		
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<u>5+</u>	<u>30%</u>	<u>30%</u>	<u>20%</u>	<u>10%</u>	<u>10%</u>

1. Mature claims-made annual rate in effect at policy issuance for the current practice and territory times the sum of the weights for the claims-made years in effect.

2. Plus mature claims-made annual rate in effect at policy issuance for the prior practice and territory times the sum of the weights for the claims-made years in effect.

For example, if a physician had practiced obstetrics and gynecology for over five years, then stopped practicing obstetrics and began to practice gynecology at the renewal two years prior to the electing the Reporting Endorsement Coverage, the appropriate base premium for the upcoming policy period would be:

Gynecology mature claims-made annual rate in effect at policy issuance times (30% + 30%),  
plus OB/GYN mature claims-made annual rate in effect at policy issuance times (20% + 10 % + 10%)

This method is applied in a similar manner if more than one practice change occurred during the previous four years. The components are pro-rated if the change occurred at a date other than the policy anniversary date.



1. STATE EXCEPTIONS

A. Policy Issuance

B. Rules

1. Item X, Amelioration, of Section 3, Classification and/or Rating Modifications and Procedures, is hereby deleted.

2. Item C, Reporting Endorsement Coverage of Section 3, Classification and/or Rating Modifications and Procedures, part VIII, Rate Adjustments for Changes in Exposure -- Claims-Made, Retroactive, and Reporting Endorsement Coverage, is replaced by:

The calculations for changes in exposure are performed by weighing the mature claims-made annual rates in effect at policy issuance for each period of differing exposures. These calculations are appropriate for changes in practice specialty or changes in rating territory that would affect a calculated rate. This method can be generalized by using the following weights and formula to calculate a rate for the upcoming year.

Claims-Made Year		Number of years policy written				
		1	2	3	4	5+
1		100%				
2		50%	50%			
3		37.5%	37.5%	25%		
4		33 1/3%	33 1/3%	22 2/9%	11 1/9%	
5+		30%	30%	20%	10%	10%

1. Mature claims-made annual rate in effect at policy issuance for the current practice and territory times the sum of the weights for the claims-made years in effect.
2. Plus mature claims-made annual rate in effect at policy issuance for the prior practice and territory times the sum of the weights for the claims-made years in effect.

For example, if a physician had practiced obstetrics and gynecology for over five years, then stopped practicing obstetrics and began to practice gynecology at the renewal two years prior to the electing the Reporting Endorsement Coverage, the appropriate base premium for the upcoming policy period would be: Gynecology mature claims-made annual rate in effect at policy issuance times (30% + 30%), plus OB/GYN mature claims-made annual rate in effect at policy issuance times (20% + 10% + 10%)

This method is applied in a similar manner if more than one practice change occurred during the previous four years. The components are pro-rated if the change occurred at a date other than the policy anniversary date.

# ILLINOIS MANUAL

HEALTH CARE PROFESSIONALS

UNDERWRITING RULES AND RATES



DIVISION OF INSURANCE  
STATE OF ILLINOIS/IDFPR  
**FILED**

MAY 01 2007

SPRINGFIELD, ILLINOIS

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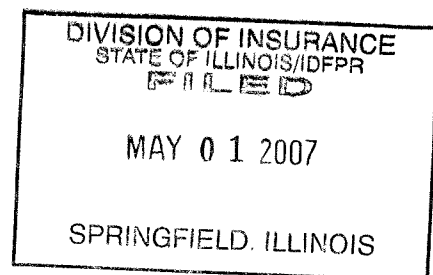
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SPRINGFIELD ILLINOIS

## **SECTION 1**

### **INTRODUCTION**



## INTRODUCTION

This manual contains the classifications and rates governing the underwriting of Physicians', Surgeons', Dentists', Podiatrists', Allied Health Professionals' and Groups' Professional Liability Insurance by ProNational Insurance Company, hereinafter referred to as "the Company."

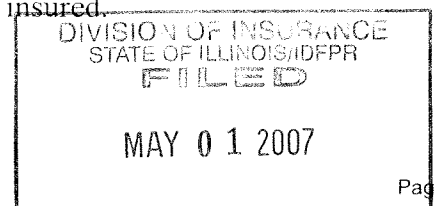
### **I. RATES AND PREMIUM CALCULATIONS**

- A. Rates apply on a per incident and annual aggregate basis. The rates for the premium classifications selected by the Company or any special situations not delineated herein are those described in the Professional Liability State Rates and Exceptions Section of this manual, with a minimum premium being \$500 (not applicable to paramedicals). If an individual's practice involves two or more rating territories or rating classifications, the highest rating territory or classification applies. Endorsements adding risks/exposures mid-term will be rated in accordance with the Rates and Rules in effect as of the endorsement effective date. Subject to Section 3., VIII, (Rate Adjustments for Changes in Exposure) of this manual, Reporting Endorsements will be rated in accordance with the Rates and Rules in effect as of the endorsement effective date. Subject to Section 3, VIII, (Rate Adjustments for Changes in Exposure) of this manual, endorsements effecting changes on risks/exposures currently insured will be rated using the Rules (e.g., rating classification, limits of liability and rating territory) in effect on the date of the change combined with the rates in effect on the later date of either i) the policy term effective date or ii) risk effective date.
- B. Refer to the Company for: Agents should refer to the Company any risk meeting one of the following criteria: a) Any risk or exposure for which there is no manual rate or applicable classification, or b) Risks developing annualized premium of \$100,000 or more for basic limits for individual (a) rating.
- C. Non-Standard Risks: Individuals rejected for standard coverage by the Company may be individually considered for coverage at an additional premium charge or other applicable coverage conditions and limitations on an individually agreed, consent-to-rate basis.
- D. Whole Dollar Premium Rule: The premiums appearing in the State Rates and Exceptions Section of this manual have been rounded to the nearest whole dollar. This procedure shall also apply to all interim premium adjustments, including endorsements or cancellations. A premium involving \$.50 or over, shall be rounded to the next higher whole dollar.

### **II. CANCELLATIONS**

Cancellations shall be made only within the parameters established by the State of policy issuance as framed in the Cancellation provisions of the policy including any State-specific endorsement thereto.

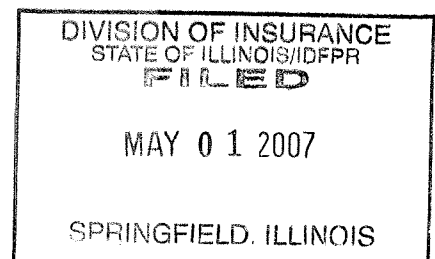
- A. By the Company: The earned premium shall be determined on a "pro rata" basis.
- B. By the Insured: The earned premium shall be determined on a "short rate" basis.
- C. Removal from the State: Subject to state provisions, the policy may be canceled by the Company after the insured no longer maintains at least 75% of his medical practice within the state of issuance, regardless of whether notice has been given by the insured.



**SECTION 2**

**PHYSICIANS & SURGEONS SPECIALTY CODES**

**AND DESCRIPTIONS**



## SPECIALTY CODES AND DESCRIPTIONS

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### Column Heading Definitions

**No Surgery:** General practitioners and specialists who do not perform surgery or assist in surgery. Incision of boils and superficial abscesses and suturing of skin and superficial fascia are not considered surgery.

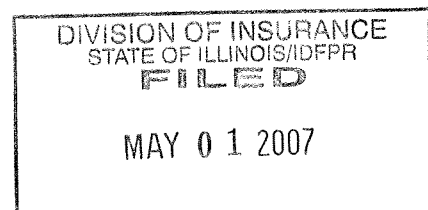
**Minor Surgery:** General practitioners and specialists who perform minor surgery or invasive procedures for diagnostic purposes, or who assist in major surgery on their own patients.

**Major Surgery:** General practitioners and specialists who perform major surgery on their own patients, or who assist in major surgery on patients of others.

## PHYSICIANS' & SURGEONS' SPECIALTY CLASSIFICATIONS & CODES

\*\*\*\*\*

<u>Specialty</u>	Industry Class Code		
	<u>No Surgery</u>	<u>Minor Surgery</u>	<u>All Other Surgery</u>
Administrative Medicine	80178	-	-
Allergy	80254	-	-
Anesthesiology	-	-	80151
Bariatrics	-	-	80476
Cardiovascular Disease	80255 -	80281(A) 80281(B)-specified procedures	80150
Colon & Rectal	-	-	80115
Dermatopathology	-	80474	-
Dermatology	80256(A)	80282	80472
Dermatology This classification applies to any dermatologist who performs the following procedures: a) excision of skin lesions with graft or flap repair; b) collagen injections.	80256(B)	-	-
Emergency Medicine This classification applies to any general practitioner or specialist primarily engaged in emergency practice at a clinic, hospital or rescue facility.	-	80102(C)	-
Emergency Medicine - Moonlighting (Refer to Classification and/or Rating Modifications & Procedures Section)	80102(A)	80102(B)	-



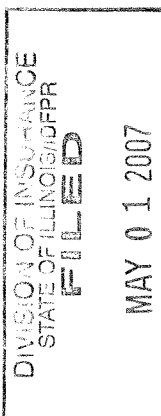
# PHYSICIANS' & SURGEONS' SPECIALTY CLASSIFICATIONS & CODES

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## Industry Class Code

<u>Specialty</u>	<u>No Surgery</u>	<u>Minor Surgery</u>	<u>All Other Surgery</u>
Family Practitioner or General Practitioner - Limited Obstetrics	-	-	80117(B)
Family Practitioner or General Practitioner – Significant Obstetrics	-	-	80117(C)
Family Practitioner or General Practitioner - No Obstetrics	80420	80421(A)* 80421(B)* 80421(C)*	80117(A) - -
Forensic/Legal Medicine	80240	-	-
Gastroenterology	80241	80274	-
General – N.O.C. This classification does not apply to any family or general practitioners or specialists who occasionally perform surgery.	-	-	80143
General Preventive Medicine	80231	-	-
Gynecology	80244	80277	80167
Hand	-	-	80169
Hematology	80245	80278	-
Hospitalist	-	80222(A) 80222(B)	-
Intensive Care Medicine	-	80283	-
Internal Medicine	80257	80284	-
Nephrology	80260	80287	-
Neurology	80261	80288	80152
Obstetrics/Gynecology	-	-	80153
Occupational Medicine	80233	-	-
Oncology	80473	80286	-
Ophthalmology	80263	80289	80114
Orthopedic – No Spinal Surgery	-	-	80154(A)
Orthopedic – Including Spinal Surgery	-	-	80154(B)

\*refer to Classification and/or Rating Modifications & Procedures Section for further definition





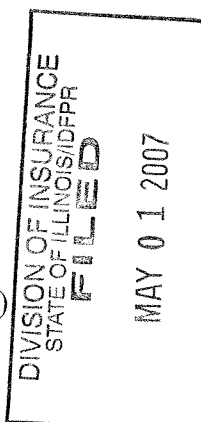
# PHYSICIANS' & SURGEONS' SPECIALTY CLASSIFICATIONS & CODES

\*\*\*\*\*

<u>Specialty</u>	<u>No Surgery</u>	<u>Industry Class Code</u>	
		<u>Minor Surgery</u>	<u>All Other Surgery</u>
Otorhinolaryngology	80265	80291	80159
Otorhinolaryngology – Including Plastic	-	-	80155
Pain Management	80475(A)	-	80475(B)-basic procedures
	-	-	80475(C)-intermediate procedures
	-	-	80475(D)-advanced procedures
Pathology	80266	-	-
Pediatrics	80267	80293**	-
Physical Medicine & Rehabilitation	80235	-	-
Physicians - N.O.C.	80268	80294	-
Plastic	-	-	80156
Podiatrist	80620	-	80621
Psychiatry	80249	-	-
Psychiatry Including Shock Therapy	80431	-	-
Public Health	80236	-	-
Pulmonary Diseases	80269	***	-
Radiology - Diagnostic	80253	80280	-
Radiology - Including Radiation Therapy	-	80425	-
Radiology – Interventional	-	80360	-
Rheumatology	80252	-	-
Semi-Retired Physicians (Refer to Classification and/or Rating Modifications and Procedures Section.)	80179	-	-
Thoracic	-	-	80144
Traumatic	-	-	80171
Urgent Care (Non-ER, no surgery)	80424(F)	-	-
Urology	80145(A)	80145(B)	80145(C)
Vascular	-	-	80146

\*\*For rating purposes, include Neonatology in this risk class.

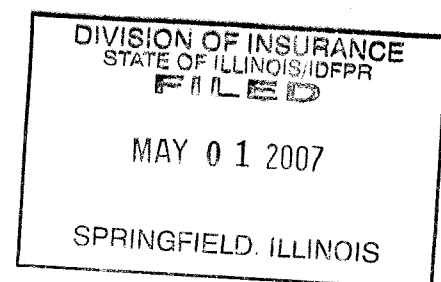
\*\*\*See Internal Medicine – Minor Surgery.



**SECTION 3**

**CLASSIFICATION AND/OR RATING MODIFICATIONS**

**AND PROCEDURES**



## CLASSIFICATION AND/OR RATING MODIFICATIONS AND PROCEDURES

### **I. "MOONLIGHTING" PHYSICIANS**

Physicians and surgeons who perform covered "moonlighting" activities may be eligible to be insured at 50% of the rate applicable to the specialty in which the physician or surgeon is "moonlighting."

Covered "moonlighting" activities include:

- A. Physicians and surgeons in active, full-time military service requesting coverage for outside activities.
- B. Full-time Federal Government employed physicians and surgeons (such as V.A. Hospital employees) requesting coverage for outside activities.
- C. Physicians and surgeons employed full-time by the State or County Health Department requesting coverage for outside activities.
- D. Residents or fellows currently attending their training program who are requesting coverage for outside activities but only while they are enrolled in such program.

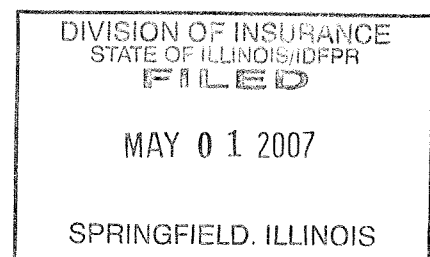
### **II. FELLOWS, RESIDENTS AND INTERNS**

- A. Coverage may be written for fellows, residents and interns practicing within the scope of their training in the teaching environment. Clinical exposure must not exceed 30 hours per week. The rate shall generally be 50% of the appropriate specialty classification, but may vary from 25% to 75% depending upon the clinical exposure of each individual rated.
- B. If fellows, residents and interns wish to practice outside their training program 100 hours or less per month, coverage may be written at a rate equal to 50% of the appropriate specialty classification. (HOWEVER, the appropriate rate for Emergency Room Moonlighting is equal to 50% of the premium assigned to Class Code 80102(A).
- C. Residents who continue to practice in the Emergency Room (part-time or full-time) during an interruption in their training for a period of time not to exceed one year, may qualify for the premium assigned to Class Code 80102(B) if they have no other clinical activities.

### **III. FAMILY PRACTICE / GENERAL PRACTICE - MINOR SURGERY**

Those Family Practice/General Practice Physicians who perform minor surgery procedures and/or assist in surgery on their own or other than their own patients will be classified as follows:

<u>Classification</u>	<u>Rating Criteria:</u>
80421(A)	Assist in major surgery on their own patients only (do not also perform minor surgical procedures).
80421(B)	Perform minor surgical procedures (may also assist in major surgery on their own patients).
80421(C)	Assist in major surgery on the patients of others (may also perform minor surgical procedures and/or assist in major surgery on their own patients).



#### IV. PART-TIME AND SE ~~MI~~ RETIRED PHYSICIANS

The Part-Time Discount is available to physicians and surgeons only, not dentists or oral surgeons:

- A. who have at least 15 years of postgraduate clinical practice experience and are scaling back their practice in anticipation of retirement; or
- B. who practice less than 20 hours per week due to family needs (caring for young children and/or ill or disabled family members); or
- C. who are required to practice on a reduced basis as a result of a physical or medical condition, with the company's approval; or
- D. who practice at least 30 hours per week at a hospital, community health center or other health care facility where medical professional liability insurance is provided by the facility. A certificate of insurance listing the Company as certificate holder must be presented annually for the credit to apply.

Insureds eligible for the New Doctor Discount are not eligible for the Part-Time Discount. Also, physicians employing or supervising paramedicals are not eligible for the Part-Time Discount.

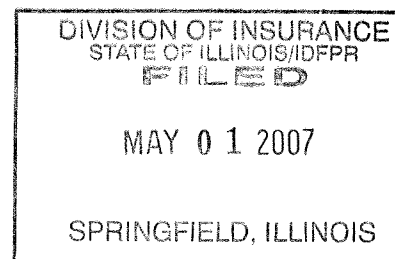
This discount is intended to more accurately rate the insured who practices his specialty on a limited basis. The available discounts are:

<u>TYPE</u>	<u>Class</u>	<u>Average Weekly Practice</u>
		<u>Hours &lt;20 hours</u>
Physician	1 to 7	50%
Surgeon	8 to 15	35%
All other		None

\* Physicians and Surgeons whose average weekly practice hours of less than 12 hours will be individually evaluated by the company.

Practice hours are defined as:

- hospital rounds,
- charting and patient planning,
- on call hours involving patient contact, whether direct or by telephone,
- consultation with other physicians, and
- patient visits/consultations.



Practice hours of physicians receiving the Part-Time Discount are subject to random audit by the Company.

#### V. LOCUM TENENS

Locum tenens coverage is provided at no additional charge for up to 45 days in any policy year and provides a shared limit with the insured. The locum tenens doctor must submit an application for Company approval in advance of the requested effective date of coverage.

#### VI. CORPORATE LIABILITY - SHARED LIMIT

No charge will be made for entities sharing in the available limits of liability of the insured physicians or dentists or other insured organizations, providing each member is insured by the Company and the risk is otherwise acceptable.

#### VII. FULL-TIME EQUIVALENT RATING

Rating of certain multi-physician groups may, at the Company's option, be determined on a full-time equivalent (FTE) unit basis. Under this rating method, policies may be issued to positions with individuals who may fill such positions identified rather than being issued to specific individuals. An FTE rate will be determined based upon the filed and approved rate for a given classification of physicians or surgeons but will be allocated based upon either the number of average hours of practice for a given specialty or the average number of patient contacts/visits in a 12 month period. A risk with fewer than 50,000 patient encounters each year will not qualify for full-time equivalent rating.

All FTE rated applications shall be referred to the Company.

## VIII. RATE ADJUSTMENTS FOR CHANGES IN EXPOSURE -- CLAIMS-MADE, RETROACTIVE, AND REPORTING ENDORSEMENT COVERAGE

### A. Claims-Made Coverage

The calculations for changes in exposure are performed by taking the difference between claims-made rates for each period of differing exposures. These calculations are appropriate for changes in practice specialty, changes in rating territory or practice in other states, changes between part-time and full-time practice, and other changes that would affect a calculated rate. Currently approved rates, classification tables and discount or surcharge factors for the appropriate state(s) are used. This method can be generalized by using the following formula to calculate a rate for the upcoming year.

1. Rate for current practice, determined using a retroactive date equal to the date that the *current* practice patterns began,
2. plus rate for prior practice, determined using a retroactive date equal to the date that the *previous* practice patterns began,
3. less rate for prior practice, determined using a retroactive date equal to the date that the *current* practice patterns began.

This method is applied in a similar manner if more than one practice change occurred during the previous four years, and the components are pro-rated if the change occurred at a date other than the policy anniversary date.

For example, if a physician had practiced obstetrics and gynecology for many years, then stopped practicing obstetrics and began to practice gynecology only, the appropriate premium for the upcoming policy period would be:

Gynecology rate for claims-made year one,  
plus OB/GYN rate for claims-made year five,  
less OB/GYN rate for claims-made year one.

This produces a blended rate, reflecting the remaining OB/GYN exposure that makes up the majority of the expected reported claims in the upcoming year, plus the initial gynecology exposure.

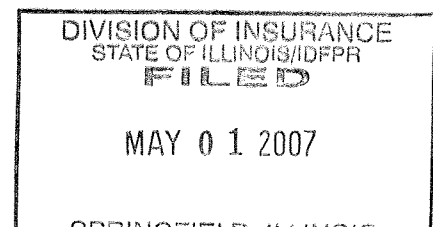
The rate for the second year of gynecology-only practice would be:

Gynecology rate for claims-made year two,  
plus OB/GYN rate for claims-made year five,  
less OB/GYN rate for claims-made year two.

This adjustment process continues for two more years, until the beginning of the fifth year in the new specialty. At that time, the blended rate would be:

Gynecology rate for claims-made year five,  
plus OB/GYN rate for claims-made year five,  
less OB/GYN rate for claims-made year five,

which is simply equal to the gynecology rate for claims-made year five.



Although this method of adjusting rates is designed to accommodate most situations, changes in medical practice often result from increasing or decreasing patient loads, additional medical training, relocation of the practice, gradual reduction in practice nearing retirement and other underwriting factors which affect the risk of loss. As a result, the Company may choose to waive the exposure change adjustment process in specific situations, thereby utilizing the current rating variables without modification. Conversely, a debit under the Scheduled Rating Plan may be applied at the underwriter's discretion, based on more than five years of practice in specialties with long claim emergence patterns, such as Pediatrics or Obstetrics.

**B. Prior Acts Coverage**

When prior acts coverage is provided, the same method is utilized, as if the insured had been with the Company during the prior acts period. Practice information regarding the prior acts period is obtained from the insurance application.

**C. Reporting Endorsement Coverage**

If reporting endorsement coverage is to be rated, the same method is utilized, substituting the reporting endorsement rates for the claims-made rates. For example, a reporting endorsement purchased at the end of the second year of gynecology practice in the obstetrics/gynecology example described above would be:

Gynecology reporting endorsement premium for claims-made year two,  
plus OB/GYN reporting endorsement premium for claims-made year five,  
less OB/GYN reporting endorsement premium for claims-made year two.

**IX. REPORTING ENDORSEMENTS (Claims-made only)**

**A. Reporting Endorsement Premium Calculation**

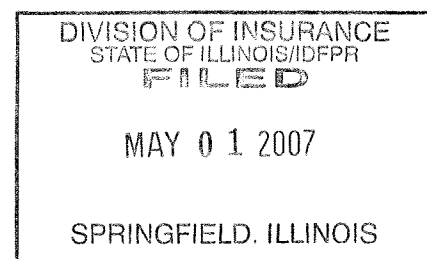
With respect to calculation of Reporting Endorsement premium, the only credits/discounts that apply are the Part-Time Discount and Deductibles credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. With respect to risks or exposures written on a consent-to-rate basis, (a) rated basis or Full-Time Equivalent Rating basis at the time the Reporting Endorsement is issued, Reporting Endorsement premium will be calculated on that same basis. If the policy is terminated during the first year, pro-rate the tail premium. For terminations during the second, third or fourth claims-made policy year, blend the applicable tail factors. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.

**B. Waiver of Reporting Endorsement Premium**

The premium for the reporting endorsement may be waived as provided by the contract in force or at the discretion of the Company.

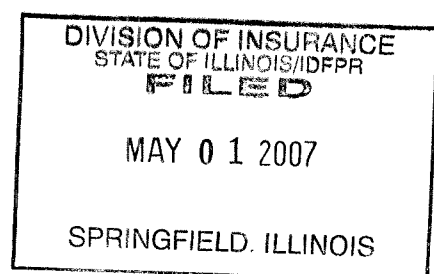
**X. RATE CHANGE AMELIORATION**

In situations where a rate change affects a single specialty by greater than 30%, a credit up to 25% may be applied to the new premium for an affected insured to lessen the single year impact of such a significant increase if, based on the underwriter's evaluation of the quality of the risk, such consideration is warranted. The underwriter will consider training and experience, longevity with the company, practice situation and claims history when making any such recommendation. Management approval is required.



## **SECTION 4**

### **PROFESSIONAL LIABILITY DISCOUNTS**



## PROFESSIONAL LIABILITY DISCOUNTS

### **I. MAXIMUM CREDIT**

Maximum credit available per insured will be limited to 40% except for the following:

- Part-time exposure rating: up to 50%. Deductible credits and attendance of a ProAssurance Loss Prevention Seminar credit may be combined with the part-time credit but no other credits or discounts apply.
- New doctor discounts: up to 50%. Deductible credits may be combined with the New Doctor discount but no other credits or discounts apply.
- Deductibles/Self-Insured Retentions
- Risks developing \$100,000 or more annualized premium

### **II. NEW DOCTOR DISCOUNT**

This discount will apply only to solo practicing physicians who have never been in practice and proceed directly into practice from training, or physicians who fit within that category except for an interim period of employment not to exceed two years. Physicians who would otherwise qualify but who are joining an established group practice insured by the Company where their clinical exposure will not exceed 30 hours per week are to be submitted to the Company for rating.

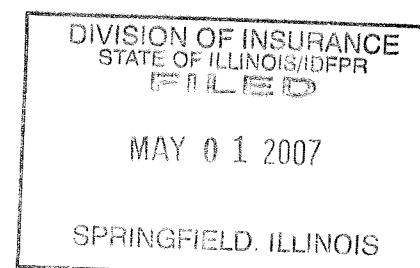
<u>Year of Coverage Since Training</u>	<u>Annual Premium Discount Per Policy</u>
Year 1	50%
Year 2	25%
Year 3	0%

### **III. RISK MANAGEMENT PREMIUM CREDITS**

Insureds who participate in risk management activities approved by the Company are eligible for the following premium credits, up to a maximum of 10%.

- A. Individual Risk Management Activities: Individual insureds may receive premium credits as indicated for completion, within the 12 months prior to application, of the following activities:

<u>Activity</u>	<u>Credit</u>
1. Successful completion of an approved fee-for-service office analysis and education program Positive response to recommendations made may result in the application of this credit for up to three policy years. Applicable only to accounts generating \$250,000 or more in annual premium.	0% - 5%
2. a. A Company sponsored Loss Prevention or other approved risk management seminar carrying at least two CME credits (annual); and/or,	0% - 5%





- b. an approved closed claim review (annual); 0% - 5%  
and/or
  - c. successful completion of an approved risk management correspondence course carrying 0% - 5%  
at least two CME credits (annual).
3. Demonstrated regular use of an approved patient information system or program. 0% - 5%

Educational activities must qualify for Continuing Medical Education credit (where applicable) to be acceptable for risk management credits. The applicant must provide proof (Certificate) of CME credits earned at the time of application. Activities submitted for risk management credits must have been completed within twelve months prior to application.

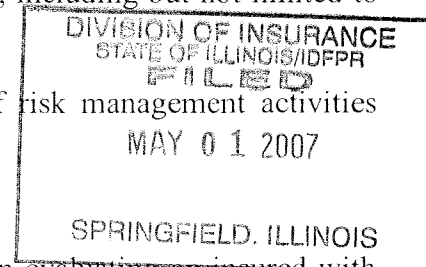
B. In addition to the above, any physician or surgeon whose practice benefits from the risk management activities of an employed practice administrator or risk manager may receive one of the following credits:

- 1. If the practice employs a full-time, qualified, professional risk manager primarily engaged in risk management and loss prevention activities, each insured may receive up to a 5% credit.
- 2. If the practice administrator or office manager participates in a Company-sponsored Loss Prevention or other risk management seminar, each insured may receive a 2% credit. Certain requirements apply:
  - a. The seminar must be designated by the Company as eligible for practice administrator credit.
  - b. Attendance must occur within the twelve months prior to application.
  - c. At least 75% of the insureds in the practice must qualify for risk management credit as a result of individual risk management activities under the terms of Section III (A)(2), above.
  - d. The practice administrator or office manager must actively manage the practice for thirty or more hours per week. In the case of shared practice management, determination of eligibility will rest with the Company.

C. Any risk management credit may be revoked or withheld for any of the following reasons:

- 1. Failure by an individual insured to certify adherence to risk management guidelines adopted by the Company and in effect at the time of application.
- 2. Demonstrable evidence which indicates that the insured has been or is practicing in violation of guidelines or underwriting criteria adopted by the Company,
- 3. Results of an underwriting audit which show serious deficiencies, including but not limited to non-compliance with specialty risk management guidelines; or
- 4. Evidence of falsification of attendance, credit or completion of risk management activities applied towards a risk management credit.
- 5. Negative claim history.

Information obtained in the process of handling a claim may be used in evaluating an insured with respect to the above condition; however, the filing of a claim or incurring any expense or indemnity on behalf of an insured shall not alone be considered grounds for reducing, revoking or withholding a credit.



#### IV. HOSPITAL BASED DISCOUNT PROGRAMS

##### A. Advanced Obstetrical Risk Management Program

Obstetrical services may be targeted with a special Advanced Obstetrical Risk Management Program relating to all phases of obstetrical services in both the physician's office or clinic and in the hospital including, but not limited to, intrapartum fetal surveillance, induction and augmentation of labor, emergency cesarean section times, documentation, and anesthesia. The physician must actively participate in the program in order to receive a discount of up to 10%.

No combination of Risk Management and Advanced Obstetrical Risk Management credits shall exceed 20%.

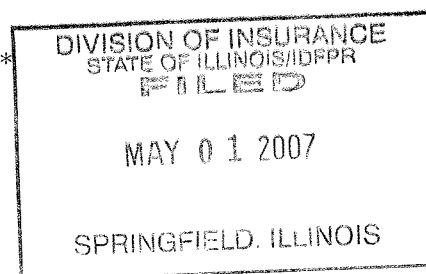
##### B. Any hospital based discount may be revoked or withheld for any of the following reasons:

1. Failure by an individual insured to certify adherence to risk management guidelines adopted by the Company and in effect at the time of application.
2. Demonstrable evidence which indicates that the insured has been or is practicing in violation of guidelines or underwriting criteria adopted by the Company.
3. Results of an underwriting audit which show serious deficiencies, including but not limited to non-compliance with specialty risk management guidelines; or
4. Evidence of falsification of attendance, credit or completion of risk management activities applied towards a risk management credit.
5. Negative claim history.

#### V. SCHEDULED RATING PROGRAM

The Company has determined that significant variability exists in the hazards faced by physicians and surgeons engaged in the practice of medicine. Exposure conditions vary with respect to:

1. Number of years experience in medicine;
2. Number of patient exposures;
3. Organization (if any) and size;
4. Medical standards review and claims review committees;
5. Other risk management practices and procedures;
6. Training, accreditation and credentialing;
7. Continuing Medical Education activities;
8. Professional liability claim experience;
9. Record-keeping practices;
10. Maintenance and utilization of certain monitoring equipment, diagnostic tests or diagnostic procedures;
11. Participation in capitation contracts; and\*
12. Insured group maintains differing limits of liability on members.\*



In order to recognize these and other factors affecting a particular practitioner or group practice, the Company proposes to apply a debit or credit to the otherwise applicable rate dependent upon the underwriter's overall evaluation of the risk.

The maximum credit will be 25%; the maximum debit will be 25%.

The Scheduled Rating Plan will apply to individuals as well as groups of two or more physicians as the Company becomes aware of variability in the risk characteristics of the individual or group. At the underwriter's discretion, objective credits otherwise applicable to an insured will not be applied in situations where a scheduled debit is deemed necessary.

\* NOTE: No credit will be given for #11 or #12 above.

## VI. DEDUCTIBLES

Deductibles may apply either to indemnity only or indemnity and allocated loss adjustment expenses (ALAE). Any discount will apply only to the primary limit premium layer (\$1M/\$3M). Deductibles are subject to approval by the company based on financial statements to be submitted by the insured and financial guarantees as required. The company reserves the right to require acceptable securitization in the amount of the per claim and/or aggregate deductible amount from any insured covered by a policy to which a deductible is attached.

### A. Individual Deductibles

See State Rates and Exceptions.

### B. Group Deductibles

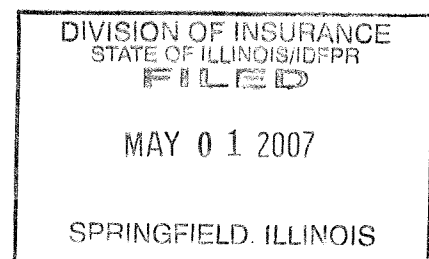
An optional deductible which limits the amount the entire group will have to pay, if multiple claims are made in a policy year, is available. Under this program, the per claim deductible continues to apply separately to each insured involved in a suit. However, the aggregate deductible applies to all insureds in the group combined thereby reducing the organization's maximum potential liability in a policy year.

When an organization is insured with a separate limit of coverage, the organization is counted when totaling the number of insureds below.

See State Rates and Exceptions.

### C. Self-Insured Retentions

Insureds may self-insure a portion of their professional and general liability risk with the Company's policy attaching in excess of the Self-Insured Retention selected. The Self-Insured Retention limit may include ALAE, or ALAE may be paid pro rata. All such policies must be referred to the Company for special consideration.



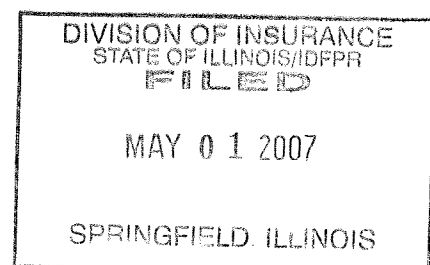
## VII. GENERAL RULES

- A. Discounts will only be applied to qualifying insureds at the initial issuance of such policy or at the next renewal date.
- B. Discounts will apply in the following order:

1. Deductible Discount (primary premium only).
2. New Doctor Discount or other resident or part-time, semi-retired discount;
3. Risk Management Discount and Scheduled Rating (apply the net credit or debit); and  
Example: Class 1, \$1M/\$3M, 1st year new doctor, Risk Management Seminar within 12 months. \$25,000 deductible. Assume manual rate \$7,500.

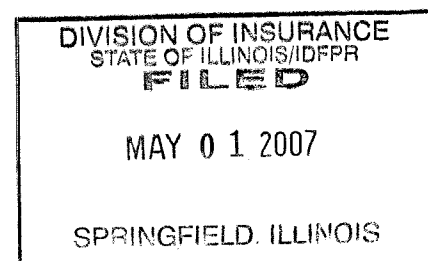
\$7,500	Manual Rate for \$1M/\$3M
<u>x .91</u>	Less 9% (Deductible Credit)
6825	
<u>x .50</u>	Less 50% (New Doctor)
3,413	Applicable Net Premium
<u>x .85</u>	Less 15% (Risk Management Programs, Scheduled Rating)
2,901	Net Premium

- C. Additional practice charges will be applied to the premium after all discounts have been applied.
- D. Corporate Liability premium will be determined after all discounts and surcharges have been applied.



**SECTION 5**

**ADDITIONAL PRACTICE CHARGES**



## ADDITIONAL PRACTICE CHARGES

### **I. MEDICAL SERVICES PROVIDED IN A STATE OUTSIDE THE STATE OF POLICY ISSUANCE**

Insureds engaging in the routine care and treatment of patients outside the state in which the policy is issued may be subject to appropriate surcharge or credit based upon rates consistent with those charged for a like risk in said state.

### **II. PARTNERSHIP - CORPORATION - PROFESSIONAL ASSOCIATION COVERAGE**

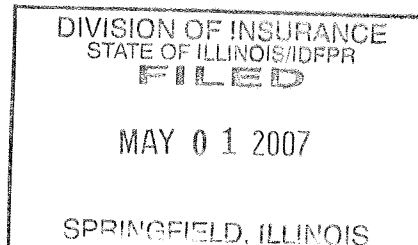
Coverage for partnerships, corporations, or professional associations may be written with a separate limit of liability. The premium charge will be a percentage (selected from the table below) of the sum of each member physician's net individual premium. For each member physician not individually insured by the Company, a premium charge will be made equal to 30% of the appropriate specialty rate if the Company agrees to provide such coverage. In order for the entity to be eligible for coverage under the separate policy, the Company must insure all member physicians or at least 60% of the physician members must be insured by the Company and the remaining physicians must be insured by another professional liability program acceptable to the Company.

<u>Number of Insureds</u>	<u>Percent</u>
2 - 5	15.0%
6 - 9	12.0%
10 - 19	9.0%
20 - 49	7.0%
50 or more	5.0%

A separate corporate limit is not available for solo practitioners or dentists. A separate corporate limit is not available to insureds purchasing limits of less than \$1M/\$3M.

### **III. PARTNERSHIP-CORPORATION-PROFESSIONAL ASSOCIATION EXTENDED REPORTING ENDORSEMENT COVERAGE**

Partnerships, corporations, or professional associations that purchase a separate limit of liability may be eligible to purchase an Extended Reporting Endorsement upon cancellation of the coverage. For the entity to be eligible for the separate limit extended reporting endorsement, all physician members insured on the policy must exercise their right to purchase an individual extended reporting endorsement. The premium charge for the entity extended reporting endorsement will be a percentage of the sum of each member physician's net individual reporting endorsement premium, based on the number of insureds and the table in Paragraph II, above.



#### IV. CLAIMS FREE CREDIT PROGRAM

A physician will be considered claims free for purposes of this credit program if:

1. no loss payment has been made during the Evaluation Period, and
2. the total of allocated loss adjustment expense [ALAE] payments made during the Evaluation Period plus any Company established reserves for loss or ALAE does not exceed \$35,000.

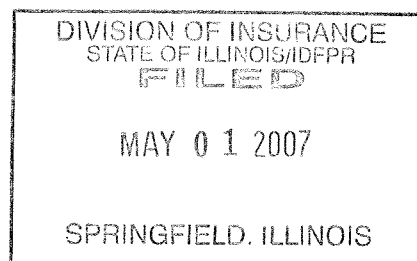
Only claims reported during the Evaluation Period shall be included in measuring the payment and reserve criteria stated above. The Evaluation Period is based upon the physician's rating class as defined in the table below and shall end on the effective date of the policy period to be rated. The Evaluation Period shall begin no earlier than the time when the physician first begins the practice of medicine following formal training (residency or a continuous period of residency and fellowships). The Company will review the claims history of each insured or applicant for the purpose of evaluating the applicability of each claim based upon the facts and circumstances of specific claims. Reported incidents that do not involve a demand for damages by a third party will not be included in the evaluation.

Class	Evaluation Period
1 - 4	10 Yrs.
5 - 9	7 Yrs.
10 - 15	5 Yrs.

The claims free physician will receive a 3% credit for compliance with the minimum Claims Free Period and will earn an additional 1% credit for each continuous claims free year thereafter up to 15% in total. However, if the physician has been continuously insured by the Company for 10 or more years, the maximum allowable Claims Free Credit that can be earned will be increased to 20%.

Credits will be applied or removed at policy inception or renewal only. Inclusion of claims history with prior carriers is subject to presentation of information acceptable to the Company. The determination of claims to be included and payment or reserve amounts to be considered will be based upon information available at the time the policy is rated, typically 60 days prior to effective date.

Notwithstanding any other provisions of this section, no insured with 3 or more claims will be eligible for a claims free credit without management approval.



## V. LEGAL DEFENSE COVERAGE

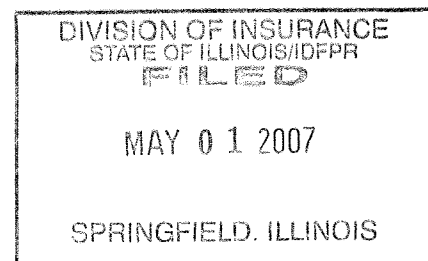
The Company offers two levels of Professional Legal Defense Coverage to insured physicians. No charge is made for the basic coverage. The most comprehensive entails a base premium charge of \$500 per insured physician. A volume discount will be given, per the schedule below.

# of Insured Physicians	Discount %
5 and under	0%
6 through 10	5%
11 through 20	10%
over 20	15%

Limits of Liability will be offered as follows:

<u># of insureds</u>	<u>"Each Covered Investigation"</u>	<u>"Each Policy Period"</u>
1 - 5	\$25,000	\$ 25,000 x (# of insureds)
6 - 10	\$25,000	\$125,000
11 - 20	\$25,000	\$175,000
21 +	\$25,000	\$225,000

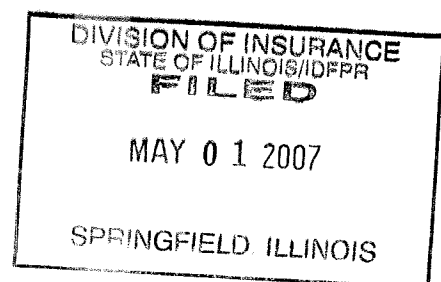
The limit of liability for "covered audits" will be \$5,000 per covered insured with a deductible of \$1,000 per audit per insured.





**SECTION 6**

**PHYSICIAN EXTENDER, PARAMEDICAL AND  
ALLIED HEALTH PROFESSIONAL LIABILITY RATING**



# **I. PHYSICIAN EXTENDER, AND PARAMEDICAL EMPLOYEES, ALLIED HEALTH EMPLOYEE PROFESSIONAL LIABILITY**

Professional employees (other than cytotechnologists, dentists, emergency medical technicians, certified registered nurse anesthetists, nurse midwives, nurse practitioners, optometrists, perfusionists, physicians, physicians' assistants, psychologists, surgeons or surgeons' assistants) are automatically included, at no additional charge, as additional insureds under policies issued to their employers. The limits of liability are on a shared basis with the employer.

The following paramedical employees may be individually covered by the Company by payment of an additional premium or covered elsewhere through a program deemed acceptable to the Company with minimum limits of liability equal to or greater than those of the insured employer. Coverage is available on a shared-limits basis or with separate individual limits. To determine the additional premium for the coverage selected, apply the appropriate factor from the premium assigned to Physician Class Codes 80420, 80151, 80153, 80266 or 80114, as specified, for the applicable claims-made year and limits of liability:

(Paramedical employees written on a shared-limits basis will be charged a fourth year claims-made premium regardless of retroactive date and the shared-limits factors stated above will always be applied to a fourth year claims-made premium.)

Employee	(Factors based on 80420)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Physician's Assistant (PA)	0.132	0.400	0.120
Surgeon's Assistant (SA)	0.132	0.400	0.120
Certified Nurse Practitioner (CNP)	0.132	0.400	0.120
Psychologist	0.040	0.111	0.033
Emergency Medical Technician (EMT)	0.004	0.010	0.003
Perfusionist	0.165	0.496	0.148

Employee	(Factors based on 80151)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Anesthetist (CRNA) – not part of an insured group	N/A	0.350	0.105
CRNA employed by an insured group - separate limits basis	N/A	0.250	0.075
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists between 2:1 and 4:1	0.150	N/A	N/A
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists no more than 2:1	0.075	N/A	N/A

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For CRNAs employed by an insured performing pain management procedures, apply the above factor to the 80475(C) ISO code and applicable rate class.

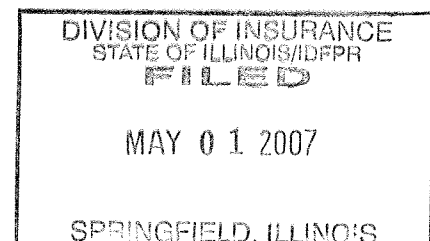
(If the ratio of employed CRNA's to Anesthesiologists exceeds 4-to-1, the Company may decline to insure the risk, or apply an additional premium, at its sole discretion.)

Employee	(Factors based on 80153)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Midwife (CNM)	0.116	0.350	0.105

Employee	(Factors based on 80266)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Cytotechnologist	0.100	N/A	N/A

Employee	(Factors based on 80114)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Optometrist	0.025	0.050	0.015

**NOTE:** When the limits of liability apply on a shared basis with the physicians of the group, the premium charge for the excess limits for the paramedical employees will be calculated at the level that the majority of physicians carry.



## II. ALLIED HEALTH PROFESSIONAL EMPLOYEES

Certain Allied Health professionals are eligible for separate insurance by the Company at individual limits of liability. The premium charge will be determined by applying the factors below to the appropriate rate for the designated Physician Class Code in the applicable rating territory.

SPECIALTY	CLASS CODE	\$1M/\$3M (Factors based on 80420)
Audiologist	80760	0.018
Cardiac Technician	80751	0.025
Casting Technician	80752	0.020
Certified Nurse Practitioner	80964	0.400
Clinical Nurse Specialist	80964	0.400
Counselor	80712	0.045
Dietitian	89761	0.018
EKG Technician	80763	0.018
Medical Assistant	80762	0.018
Medical Lab Technician	80711	0.018
Nurse	80998	0.018
Nurse - Student	82998	0.005
Nurse, RN Perform X-Ray Therapy	80714	0.018
Occupational Therapist	80750	0.025
O.R. Technician	80758	0.125
Ophthalmic Assistant	80755	0.018
Orthopedic Technician	80756	0.020
Perfusionist	80764	0.500
Pharmacist	59112	0.025
Phlebotomist	80753	0.018
Physical Therapist (Emp)	80945	0.025
Physical Therapist (Ind)	80946	0.090
Physical Therapy Aide	80995	0.018
Physiotherapist	80938	0.018
Psychologist	80912	0.111
Pump Technician	88888	0.020
Respiratory Therapist	80601	0.122
Social Worker	80911	0.045
Sonographer	80754	0.018
X-Ray/Radiologic Technician	80713	0.018
X-Ray Therapy Technician	80716	0.025

(Factors based on 80211)

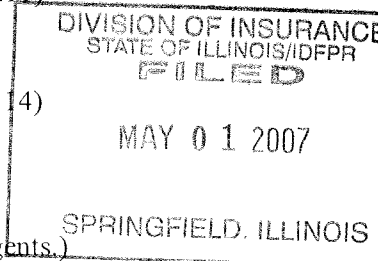
Dental Assistant	80207	0.100
Dental Hygienist	80208	0.100

(Factors based on 80144)

Optometrist (Optical)	80944	0.032
Optometrist (Employee*)	80944	**See note below
Optometrist (Independent**)	80944	**See note below

\*25% of an Ophthalmologists base premium. (If administering topical ocular pharmaceutical agents.)

\*\*75% of an Ophthalmologists base premium. (If administering topical ocular pharmaceutical agents.)



At the discretion of the underwriter, additional insured status may be granted to the non-insured allied health entity for a 10% additional charge. The entity will share in the limits of liability of the insured allied health provider but only for the activities of such provider.

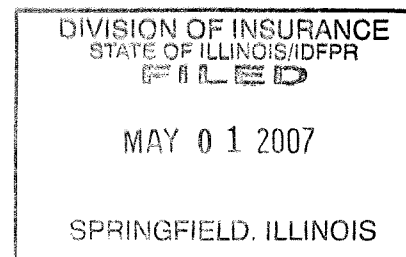
Reporting Endorsements are available to Allied Health Professionals insured under separate policies by application of the factors below.

<u>Prior Year Claims-Made</u>	<u>Factors</u>
1	1.00
2	1.25
3+	1.50

**STEP-RATING FACTORS**

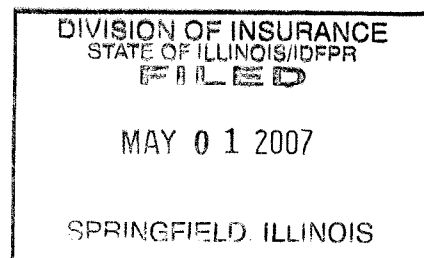
First Year	50% of mature premium
Second Year	80% of mature premium
Third Year	100% of mature premium

Mature premiums under \$500 are not eligible for the step-rating factors.



**SECTION 7**

**DENTAL PROFESSIONAL LIABILITY**



## I. DENTAL SPECIALTY CODES & CLASSIFICATIONS

### DENTISTS - CLASS 1A

- 80213 Applies to dentists who perform dentistry on patients who have been treated with local anesthesia or by inhalation sedation and does not apply to treatment involving any general anesthesia or intravenous or intramuscular agent unless performed in a hospital. **This class does not apply to dentists performing extractions, root canals or other oral surgery or endodontic procedures.** This class does not apply to oral surgeons.

### DENTISTS - CLASS 1

- 80211 Applies to dentists who perform dentistry on patients who have been treated with local anesthesia or by inhalation sedation and does not apply to treatment involving any general anesthesia or intravenous or intramuscular agent unless performed in a hospital. This class does not apply to dentists performing the initial placement of dental implants. This class does not apply to oral surgeons.
- 80214 Applies to orthodontists and endodontists who perform dentistry on patients who have been treated with local anesthesia or by inhalation sedation and does not apply to treatment involving any general anesthesia or intravenous or intramuscular agent unless performed in a hospital. This class does not apply to dentists performing the initial placement of dental implants. This class does not apply to oral surgeons.
- 80215 Applies to periodontists who perform dentistry on patients who have been treated with local anesthesia or by inhalation sedation and does not apply to treatment involving any general anesthesia or intravenous or intramuscular agent unless performed in a hospital. This class does not apply to dentists performing the initial placement of dental implants. This class does not apply to oral surgeons.

### DENTISTS - CLASS 2

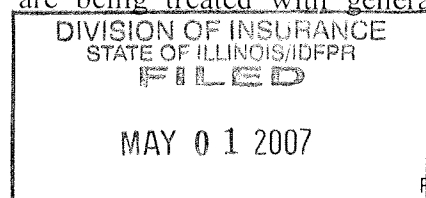
- 80211.1 Applies to dentists, endodontists and periodontists as defined for Class 1 but, in addition, permits the initial placement of dental implants. This classification also permits dentistry on patients who have been treated by intravenous or intramuscular sedation in the office, but only if the sedation is administered by a Dental or Medical Anesthetist. If intravenous or intramuscular sedation is performed in a hospital only, Class 1 will apply. This class does not apply to oral surgeons.

### DENTISTS - CLASS 3

- 80209 Applies to dentists as defined for Classes 1 or 2 but, in addition, permits dentistry on patients who have been treated by intravenous or intramuscular sedation in the office, administered by the dentist or a CRNA. If intravenous or intramuscular sedation is performed in a hospital only, Class 1 or 2 will apply, as appropriate. This class does not apply to oral surgeons.

### ORAL SURGERY - CLASS 4

- 80210 Includes all oral surgeons and also applies to dentists as defined in Classes 1A through 3 who additionally perform dentistry on patients who are being treated with general anesthesia in the office.



## II. PARADENTAL EMPLOYEE COVERAGE

Coverage on a shared limits basis is automatically provided for professional employees of the Policyholder or an insured under the policy with no additional charge (e.g., dental assistants, dental hygienists and lab technicians).

While a dental insured's insured paradecimal employees are automatically covered under the policy, a premium charge for Certified Registered Nurse Anesthetists (CRNAs) will be made as indicated in Section 6, I – Employed Certified Registered Nurse Anesthetist.

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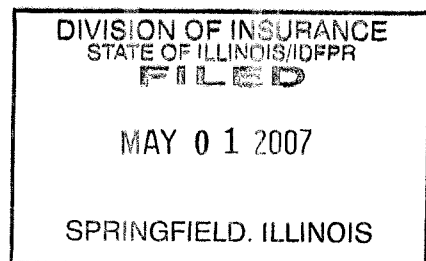
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**SECTION 8**

**STATE RATES AND EXCEPTIONS – DENTISTS AND ORAL SURGEONS**

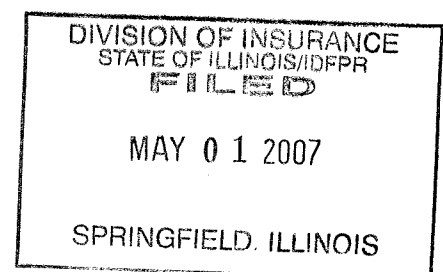


## I. RATES

### A. Dental Rating Classes – Illinois

The following indicates the specialty classification codes applicable to the rating classes on the following pages:

<u>Rating Classes</u>	<u>Industry Class Codes</u>
1A	80213
1	80211 80214 80215
2	80211.1
3	80209
4	80210



**B. Dentists Professional Liability Rates****1. Claims-Made Rates by Year**

Territory 001 - Cook, Madison, St. Clair and Will Counties

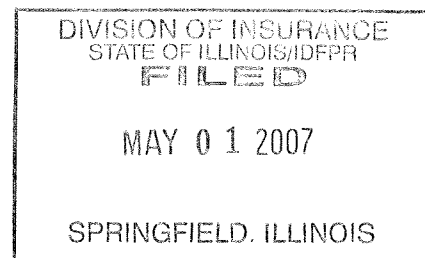
Class Code	\$250,000 / \$750,000				
	1	2	3	4	5+
1A	646	1,159	1,501	1,705	1,910
1	774	1,416	1,843	2,090	2,337
2	935	1,736	2,271	2,571	2,872
3	1,736	3,340	4,409	4,976	5,544
4	4,943	9,753	12,960	14,597	16,233

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson  
Kankakee, Macon, Randolph, Washington and Williamson Counties

Class Code	\$250,000 / \$750,000				
	1	2	3	4	5+
1A	493	853	1,093	1,246	1,399
1	583	1,033	1,333	1,516	1,699
2	695	1,258	1,633	1,854	2,074
3	1,258	2,383	3,133	3,541	3,949
4	3,508	6,883	9,133	10,291	11,449

Territory 003 – Remainder of State

Class Code	\$250,000 / \$750,000				
	1	2	3	4	5+
1A	421	710	902	1,032	1,161
1	493	854	1,095	1,248	1,401
2	584	1,035	1,335	1,519	1,702
3	1,035	1,936	2,537	2,871	3,205
4	2,838	5,543	7,347	8,281	9,216



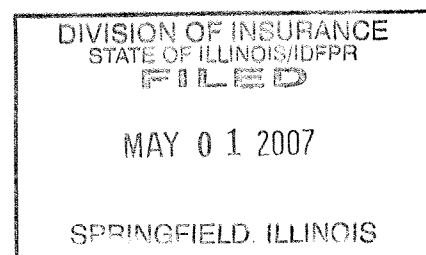
**1. Claims-Made Ra by Year (cont.)**

Territory 004 – DuPage, Kane, Lake, McHenry and Sangamon Counties

Class Code	\$250,000 / \$750,000				
	1	2	3	4	5+
1A	569	1,006	1,297	1,476	1,654
1	678	1,224	1,588	1,803	2,018
2	815	1,497	1,952	2,212	2,473
3	1,497	2,861	3,771	4,259	4,747
4	4,225	8,318	11,046	12,444	13,841

Territory 005 – Jackson and Vermilion Counties

Class Code	\$250,000 / \$750,000				
	1	2	3	4	5+
1A	595	1,057	1,365	1,552	1,739
1	710	1,288	1,673	1,899	2,124
2	855	1,577	2,058	2,332	2,606
3	1,577	3,021	3,983	4,498	5,012
4	4,465	8,797	11,684	13,162	14,639



# 1. Claims-Made Rates by Year (cont.)

Territory 001 - Cook, Madison, St. Clair and Will Counties

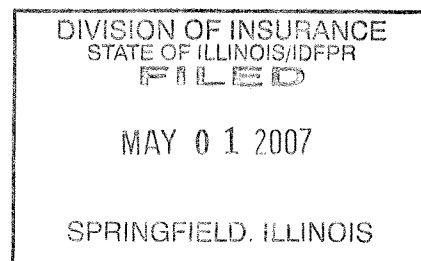
Class Code	\$500,000 / \$1,500,000				
	1	2	3	4	5+
1A	867	1,601	2,090	2,368	2,646
1	1,050	1,968	2,580	2,919	3,258
2	1,280	2,427	3,191	3,607	4,023
3	2,427	4,721	6,250	7,048	7,846
4	7,015	13,897	18,485	20,812	23,139

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson  
Kankakee, Macon, Randolph, Washington and Williamson Counties

Class Code	\$500,000 / \$1,500,000				
	1	2	3	4	5+
1A	648	1,163	1,506	1,711	1,916
1	777	1,420	1,850	2,097	2,345
2	938	1,742	2,279	2,580	2,882
3	1,742	3,352	4,425	4,995	5,564
4	4,961	9,790	13,009	14,652	16,294

Territory 003 – Remainder of State

Class Code	\$500,000 / \$1,500,000				
	1	2	3	4	5+
1A	546	958	1,234	1,404	1,575
1	649	1,165	1,509	1,714	1,919
2	778	1,423	1,853	2,101	2,349
3	1,423	2,713	3,573	4,036	4,499
4	4,003	7,873	10,453	11,777	13,100



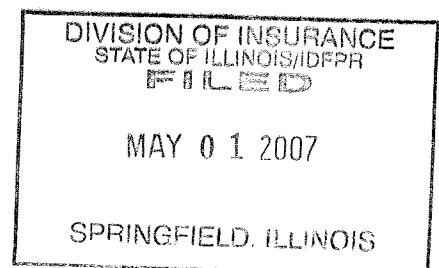
# 1. Claims-Made Rates by Year (cont.)

Territory 004 – DuPage, Kane, Lake, McHenry and Sangamon Counties

Class Code	\$500,000 / \$1,500,000				
	1	2	3	4	5+
1A	757	1,382	1,798	2,040	2,281
1	913	1,694	2,215	2,508	2,802
2	1,109	2,085	2,735	3,094	3,452
3	2,085	4,036	5,337	6,021	6,705
4	5,988	11,843	15,747	17,732	19,716

Territory 005 – Jackson and Vermilion Counties

Class Code	\$500,000 / \$1,500,000				
	1	2	3	4	5+
1A	794	1,455	1,896	2,149	2,403
1	959	1,785	2,336	2,645	2,954
2	1,166	2,199	2,887	3,265	3,642
3	2,199	4,265	5,642	6,364	7,085
4	6,330	12,528	16,660	18,759	20,858



# 1. Claims-Made Rates by Year (cont.)

Territory 001 - Cook, Madison, St. Clair and Will Counties

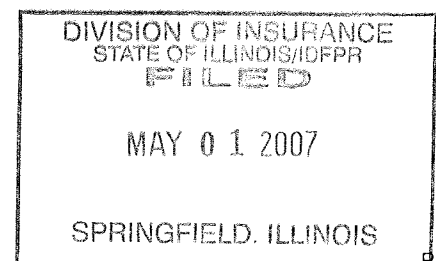
Class Code	\$1,000,000 / \$3,000,000				
	1	2	3	4	5+
1A	1,081	2,030	2,662	3,011	3,361
1	1,318	2,504	3,294	3,723	4,151
2	1,615	3,097	4,085	4,612	5,139
3	3,097	6,060	8,036	9,057	10,079
4	9,024	17,916	23,843	26,840	29,837

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson  
Kankakee, Macon, Randolph, Washington and Williamson Counties

Class Code	\$1,000,000 / \$3,000,000				
	1	2	3	4	5+
1A	798	1,464	1,907	2,162	2,417
1	965	1,796	2,351	2,661	2,972
2	1,173	2,212	2,905	3,285	3,665
3	2,212	4,292	5,678	6,404	7,131
4	6,371	12,610	16,769	18,881	20,994

Territory 003 – Remainder of State

Class Code	\$1,000,000 / \$3,000,000				
	1	2	3	4	5+
1A	666	1,200	1,555	1,766	1,977
1	800	1,466	1,911	2,166	2,422
2	966	1,800	2,355	2,666	2,977
3	1,800	3,466	4,577	5,166	5,755
4	5,133	10,133	13,467	15,167	16,867



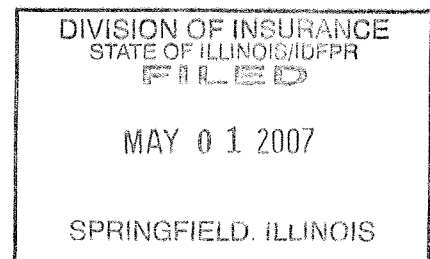
**1. Claims-Made Rates by Year (cont.)**

Territory 004 – DuPage, Kane, Lake, McHenry and Sangamon Counties

Class Code	\$1,000,000 / \$3,000,000				
	1	2	3	4	5+
1A	940	1,747	2,285	2,587	2,889
1	1,141	2,150	2,823	3,192	3,561
2	1,394	2,654	3,495	3,948	4,402
3	2,654	5,176	6,857	7,731	8,605
4	7,698	15,262	20,306	22,861	25,415

Territory 005 – Jackson and Vermilion Counties

Class Code	\$1,000,000 / \$3,000,000				
	1	2	3	4	5+
1A	987	1,841	2,410	2,728	3,046
1	1,200	2,268	2,980	3,369	3,758
2	1,467	2,802	3,692	4,170	4,648
3	2,802	5,471	7,250	8,173	9,096
4	8,140	16,147	21,485	24,188	26,890





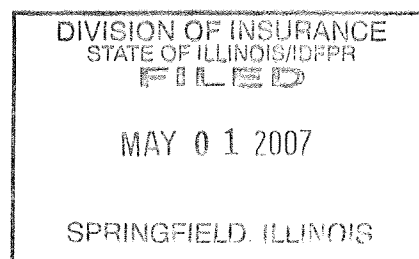
## 2. Extended Reporting Period Endorsement (Tail Coverage)

### Extended Reporting Period (Tail) Factors By Month

Claims-Made  
Year

	1	2	3	4	5	6	7	8	9	10	11	12
1	0.150	0.230	0.310	0.380	0.450	0.520	0.590	0.660	0.730	0.800	0.870	0.940
2	1.010	1.080	1.150	1.220	1.280	1.340	1.400	1.460	1.520	1.580	1.640	1.700
3	1.730	1.760	1.790	1.820	1.850	1.880	1.900	1.920	1.940	1.960	1.980	2.000
4	2.030	2.067	2.100	2.133	2.167	2.200	2.233	2.267	2.300	2.333	2.367	2.400
5	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400

Example: An insured who has a third year claims-made policy and decides to cancel after three months have elapsed would purchase tail coverage at the year 3, three month factor (1.790), times the mature claims-made annual rate in effect at policy issuance. For claims-made year 5 and over the 2.400 factor applies.



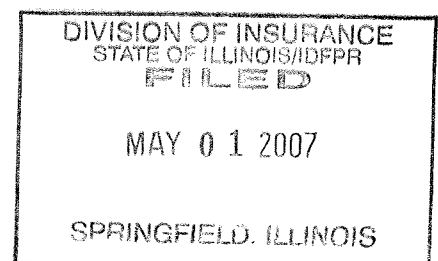
### C. Excess Limits of Liability for Dentists and Oral Surgeons – Claims-made

Excess limits premium shall be derived by applying the appropriate factor below to the appropriate primary rate. Excess limits are only offered above underlying limits of \$1,000,000.

Factors for limits above \$1 Million/\$3 Million Primary:

Excess Limits	Factors
\$1M	0.1977
\$2M	0.3164

These factors are based upon negotiated reinsurance agreements. Deviation from these factors up to 25% based upon negotiated agreements with reinsurers and/or underwriting judgment may apply.



## II. STATE EXCEPTIONS

### A. Policy Issuance

### B. Rules

1. Item X, Rate Change Amelioration, of Section 3, Classification and/or Rating Modifications and Procedures, is hereby deleted.
2. Item C. Reporting Endorsement Coverage of Section 3, Classification and/or Rating Modifications and Procedures, part VIII. Rate Adjustments for Changes in Exposure -- Claims-Made, Retroactive, and Reporting Endorsement Coverage, is replaced by:

The calculations for changes in exposure are performed by weighting the mature claims-made annual rates in effect at policy issuance for each period of differing exposures. These calculations are appropriate for changes in practice specialty or changes in rating territory that would affect a calculated rate. This method can be generalized by using the following weights and formula to calculate a rate for the upcoming year.

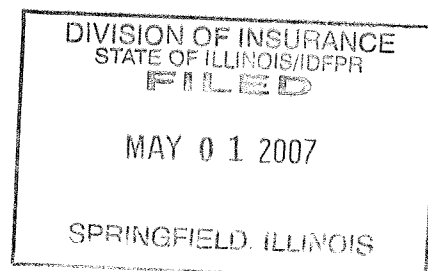
Number of years policy written	Claims-Made Year				
	1	2	3	4	5+
1	100%				
2	50%	50%			
3	37.5%	37.5%	25%		
4	33 1/3%	33 1/3%	22 2/9%	11 1/9%	
5+	30%	30%	20%	10%	10%

1. Mature claims-made annual rate in effect at policy issuance for the current practice and territory times the sum of the weights for the claims-made years in effect.
2. Plus mature claims-made annual rate in effect at policy issuance for the prior practice and territory times the sum of the weights for the claims-made years in effect.

For example, if a physician had practiced obstetrics and gynecology for over five years, then stopped practicing obstetrics and began to practice gynecology at the renewal two years prior to the electing the Reporting Endorsement Coverage, the appropriate base premium for the upcoming policy period would be:

Gynecology mature claims-made annual rate in effect at policy issuance times (30% + 30%), plus OB/GYN mature claims-made annual rate in effect at policy issuance times (20% + 10% + 10%)

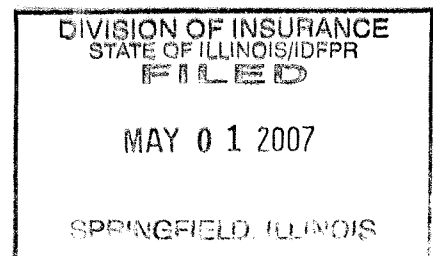
This method is applied in a similar manner if more than one practice change occurred during the previous four years. The components are pro-rated if the change occurred at a date other than the policy anniversary date.



3. Section 4, Professional Liability Discounts, is hereby amended by adding the following:

**VIII. ANNUAL PREMIUM PAYMENT DISCOUNT**

A discount of 1.5% of the policy premium will be applied if the insured pays the premium in full prior to the inception date of the policy. This discount is not available if the initial policy term is less than six months. If the full premium is not received by the Company by the policy effective date, the discount will be withdrawn, the policy will be rated without the discount and the insured will be billed for the additional premium.



### III. STATE REQUIREMENTS

#### A. Policy Issuance

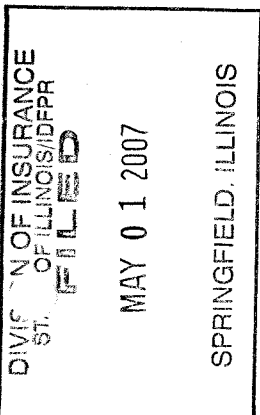
1. The Illinois State Law Endorsement must be attached to the policy at the time of issuance.
2. Item III, Quarterly Installment Options, is hereby added to Section 1, Introduction, as follows:

#### III. QUARTERLY INSTALLMENT OPTIONS

1. Quarterly Installment Option One – (40/20/20/20)
  - a. A minimum initial deposit required, which shall be 40 percent of the estimated total premium due at policy inception;
  - b. The remaining premium spread equally among the second, third and fourth installments at 20 percent of the estimated total premium, and due 3, 6 and 9 months from policy inception, respectively;
  - c. No interest or installment charges;
  - d. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to the policy shall be billed immediately as a separate transaction; and
  - e. The installment plan will be limited to insureds whose premium exceeds \$500.00 per year.
2. Quarterly Installment Option Two – (35/25/25/15)
  - a. A minimum initial deposit required, which shall be 35 percent of the estimated total premium due at policy inception;
  - b. The remaining premium will be 25 percent for the second and third installments and 15 percent for the fourth installment, and due 3, 6 and 9 months from policy inception, respectively;
  - c. No interest or installment charges;
  - d. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to the policy shall be billed immediately as a separate transaction; and
  - e. The installment plan will be limited to insureds whose premium exceeds \$500.00 per year.

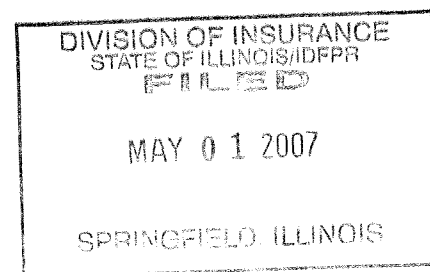
#### B. Rules

1. Item I, Rates and Premium Calculations, of Section 1, Introduction, is hereby amended.
  - A. Rates apply on a per incident and annual aggregate basis. The rates for the premium classifications selected by the Company or any special situations not delineated herein are those described in the Professional Liability State Rates and Exceptions Section of this manual, with a minimum premium being \$500 (not applicable to paramedicals). If an individual's practice involves two or more rating territories or rating classifications, the highest rating territory or classification applies. Endorsements adding risks/exposures mid-term will be rated in accordance with the Rates and Rules in effect as of the endorsement effective date. Subject to Section 3., VIII, (Rate Adjustments for Changes in Exposure) of this manual, Reporting Endorsements will be rated in accordance with the Rates and Rules in effect as of the policy effective date. Subject to Section 3, VIII, (Rate Adjustments for Changes in Exposure) of this manual, endorsements effecting changes on risks/exposures currently insured will be rated using the Rules (e.g., rating classification, limits of liability and rating territory) in effect on the date of the change combined with the rates in effect on the later date of either i) the policy term effective date or ii) risk effective date.



2. Item IX, Reporting Endorsements, of Section 3, Classification and/or Rating Modifications and Procedures, is hereby amended.

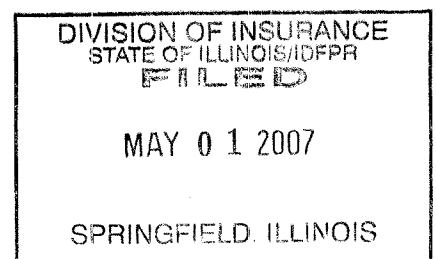
With respect to calculation of Reporting Endorsement premium, the only credits/discounts that apply are the Part-Time Discount and Deductibles credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. With respect to risks or exposures written on a consent-to-rate basis, (a) rated basis or Full-Time Equivalent Rating basis at the time the Reporting Endorsement is issued, Reporting Endorsement premium will be calculated on that same basis. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.



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**SECTION 9**

**STATE RATES AND EXCEPTIONS – PHYSICIANS, SURGEONS AND  
PODIATRISTS**

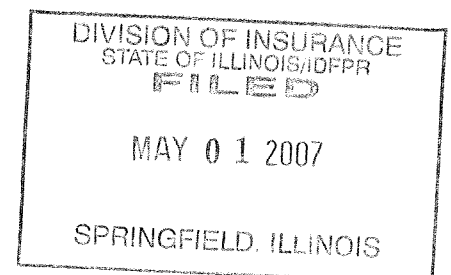


## I. RATES

### A. Rating Classes - Illinois

The following indicates the classification codes that are applicable to the rating classes on the following pages:

<u>Rating Class</u>	<u>Industry Class Codes</u>					
1	80102(A) 80178	80179 80231	80235 80236	80240 80254	80256(A) 80265	
2	80233 80238	80249 80252	80256(B) 80263	80267 80474	80620	
3	80102(B) 80145(A) 80151	80222(A) 80244 80245	80255 80257 80260	80266 80268 80282	80289 80420 80431	80473 80621
4	80114 80145(B)	80222(B) 80241	80246 80253	80261 80269	80421(A)	
5	80145(C) 80274 80278	80280 80283 80284	80286 80287 80288	80291 80293 80294	80360 80421(B) 80425	80424(F)
6	80115 80159	80167 80277	80281(A) 80421(C)	80472		
7	80102(C)	80117(A)	80281(B)	80475(A)		
8	80117(B)					
9	80117(C)	80143	80154(A)	80155	80156	80169
10	80146	80150				
11	80154(B)	80171	80475(B)			
12	80144	80153				
13	80475(C)	80476				
14	80152	80475(D)				
15	Not used at this time.					





## B. Physicians and Surgeons Professional Liability Rates

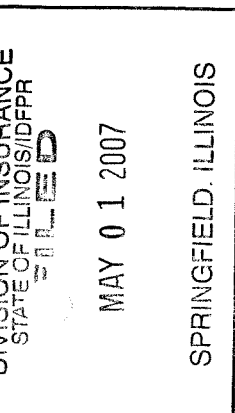
### 1. Claims-Made Rates by Year

Territory 001 - Cook, Madison, St. Clair and Will Counties

Class Code	\$250,000 / \$750,000				
	1	2	3	4	5+
1	4,611	7,801	9,927	10,990	12,054
2	6,206	10,990	14,180	15,775	17,369
3	7,801	14,180	18,433	20,559	22,685
4	9,396	17,369	22,685	25,343	28,001
5	10,990	20,559	26,938	30,128	33,317
6	12,904	24,386	32,041	35,869	39,696
7	14,180	26,938	35,444	39,696	43,949
8	16,795	32,169	42,418	47,542	52,667
9	20,559	39,696	52,454	58,833	65,212
10	23,749	46,075	60,960	68,402	75,844
11	26,938	52,454	69,465	77,971	86,476
12	30,128	58,833	77,971	87,539	97,108
13	33,317	65,212	86,476	97,108	107,740
14	42,886	84,350	111,992	125,814	139,635
15	46,075	90,729	120,498	135,382	150,267

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson  
Kankakee, Macon, Randolph, Washington and Williamson Counties

Class Code	\$250,000 / \$750,000				
	1	2	3	4	5+
1	3,654	5,887	7,376	8,120	8,864
2	4,771	8,120	10,352	11,469	12,585
3	5,887	10,352	13,329	14,818	16,306
4	7,003	12,585	16,306	18,167	20,027
5	8,120	14,818	19,283	21,516	23,749
6	9,459	17,497	22,855	25,535	28,214
7	10,352	19,283	25,237	28,214	31,191
8	12,183	22,945	30,119	33,706	37,293
9	14,818	28,214	37,145	41,610	46,075
10	17,051	32,679	43,098	48,308	53,518
11	19,283	37,145	49,052	55,006	60,960
12	21,516	41,610	55,006	61,704	68,402
13	23,749	46,075	60,960	68,402	75,844
14	30,447	59,471	78,821	88,496	98,171
15	32,679	63,937	84,775	95,194	105,613



# 1. Claims-Made Rates by Year (cont.)

Territory 003 – Remainder of State

Class Code	\$250,000 / \$750,000				
	1	2	3	4	5+
1	3,208	4,994	6,185	6,780	7,376
2	4,101	6,780	8,566	9,459	10,352
3	4,994	8,566	10,948	12,139	13,329
4	5,887	10,352	13,329	14,818	16,306
5	6,780	12,139	15,711	17,497	19,283
6	7,852	14,282	18,569	20,712	22,855
7	8,566	15,711	20,474	22,855	25,237
8	10,031	18,640	24,380	27,249	30,119
9	12,139	22,855	30,000	33,572	37,145
10	13,925	26,428	34,763	38,931	43,098
11	15,711	30,000	39,526	44,289	49,052
12	17,497	33,572	44,289	49,648	55,006
13	19,283	37,145	49,052	55,006	60,960
14	24,642	47,861	63,341	71,081	78,821
15	26,428	51,434	68,104	76,440	84,775

Territory 004 – DuPage, Kane, Lake, McHenry and Sangamon Counties

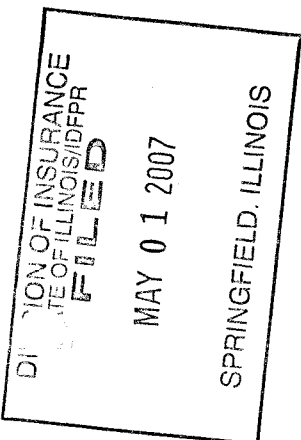
Class Code	\$250,000 / \$750,000				
	1	2	3	4	5+
1	4,133	6,844	8,651	9,555	10,459
2	5,488	9,555	12,266	13,622	14,977
3	6,844	12,266	15,881	17,688	19,496
4	8,200	14,977	19,496	21,755	24,014
5	9,555	17,688	23,111	25,822	28,533
6	11,182	20,942	27,448	30,702	33,955
7	12,266	23,111	30,340	33,955	37,570
8	14,489	27,557	36,269	40,624	44,980
9	17,688	33,955	44,799	50,222	55,644
10	20,400	39,377	52,029	58,355	64,681
11	23,111	44,799	59,259	66,488	73,718
12	25,822	50,222	66,488	74,622	82,755
13	28,533	55,644	73,718	82,755	91,792
14	36,666	71,911	95,407	107,155	118,903
15	39,377	77,333	102,636	115,288	127,940

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1. Claims-Made Rates by Year (cont.)

Territory 005 – Jackson and Vermilion Counties

Class Code	\$250,000 / \$750,000				
	1	2	3	4	5+
1	4,292	7,163	9,077	10,034	10,990
2	5,728	10,034	12,904	14,339	15,775
3	7,163	12,904	16,732	18,645	20,559
4	8,598	15,775	20,559	22,951	25,343
5	10,034	18,645	24,386	27,257	30,128
6	11,756	22,090	28,979	32,424	35,869
7	12,904	24,386	32,041	35,869	39,696
8	15,258	29,094	38,318	42,930	47,542
9	18,645	35,869	47,351	53,092	58,833
10	21,516	41,610	55,006	61,704	68,402
11	24,386	47,351	62,661	70,316	77,971
12	27,257	53,092	70,316	78,927	87,539
13	30,128	58,833	77,971	87,539	97,108
14	38,739	76,057	100,935	113,374	125,814
15	41,610	81,798	108,590	121,986	135,382



# 1. Claims-Made Rates by Year (cont.)

Territory 001 - Cook, Madison, St. Clair and Will Counties

Class Code	\$500,000 / \$1,500,000				
	1	2	3	4	5+
1	5,985	10,548	13,590	15,111	16,633
2	8,267	15,111	19,675	21,956	24,238
3	10,548	19,675	25,759	28,801	31,843
4	12,830	24,238	31,843	35,646	39,449
5	15,111	28,801	37,928	42,491	47,054
6	17,849	34,277	45,229	50,705	56,180
7	19,675	37,928	50,096	56,180	62,265
8	23,416	45,411	60,074	67,406	74,737
9	28,801	56,180	74,433	83,560	92,686
10	33,364	65,307	86,602	97,249	107,897
11	37,928	74,433	98,770	110,939	123,108
12	42,491	83,560	110,939	124,629	138,318
13	47,054	92,686	123,108	138,318	153,529
14	60,744	120,065	159,613	179,387	199,161
15	65,307	129,192	171,782	193,077	214,372

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson  
Kankakee, Macon, Randolph, Washington and Williamson Counties

Class Code	\$500,000 / \$1,500,000				
	1	2	3	4	5+
1	4,616	7,810	9,940	11,005	12,069
2	6,213	11,005	14,199	15,796	17,393
3	7,810	14,199	18,458	20,587	22,717
4	9,407	17,393	22,717	25,379	28,041
5	11,005	20,587	26,976	30,170	33,364
6	12,921	24,420	32,087	35,920	39,753
7	14,199	26,976	35,494	39,753	44,012
8	16,818	32,214	42,479	47,611	52,743
9	20,587	39,753	52,530	58,918	65,307
10	23,782	46,141	61,048	68,501	75,954
11	26,976	52,530	69,566	78,084	86,602
12	30,170	58,918	78,084	87,667	97,249
13	33,364	65,307	86,602	97,249	107,897
14	42,947	84,472	112,156	125,998	139,839
15	46,141	90,861	120,674	135,580	150,487

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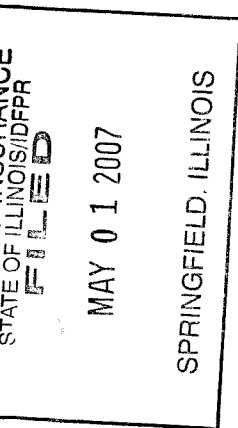
# 1. Claims-Made Rates by Year (cont.)

Territory 003 – Remainder of State

Class Code	\$500,000 / \$1,500,000				
	1	2	3	4	5+
1	3,977	6,533	8,236	9,088	9,940
2	5,255	9,088	11,643	12,921	14,199
3	6,533	11,643	15,051	16,754	18,458
4	7,810	14,199	18,458	20,587	22,717
5	9,088	16,754	21,865	24,420	26,976
6	10,621	19,821	25,954	29,020	32,087
7	11,643	21,865	28,679	32,087	35,494
8	13,739	26,056	34,267	38,373	42,479
9	16,754	32,087	42,308	47,419	52,530
10	19,310	37,197	49,123	55,085	61,048
11	21,865	42,308	55,937	62,751	69,566
12	24,420	47,419	62,751	70,418	78,084
13	26,976	52,530	69,566	78,084	86,602
14	34,642	67,862	90,009	101,082	112,156
15	37,197	72,973	96,823	108,749	120,674

Territory 004 – DuPage, Kane, Lake, McHenry and Sangamon Counties,

Class Code	\$500,000 / \$1,500,000				
	1	2	3	4	5+
1	5,301	9,179	11,765	13,058	14,351
2	7,240	13,058	16,937	18,876	20,815
3	9,179	16,937	22,108	24,694	27,280
4	11,119	20,815	27,280	30,512	33,745
5	13,058	24,694	32,452	36,330	40,209
6	15,385	29,349	38,658	43,312	47,967
7	16,937	32,452	42,795	47,967	53,138
8	20,117	38,813	51,276	57,508	63,740
9	24,694	47,967	63,482	71,239	78,996
10	28,573	55,724	73,825	82,875	91,926
11	32,452	63,482	84,168	94,511	104,855
12	36,330	71,239	94,511	106,148	117,784
13	40,209	78,996	104,855	117,784	130,713
14	51,845	102,269	135,885	152,692	169,500
15	55,724	110,026	146,228	164,329	182,429



# 1. Claims-Made Rates by Year (cont.)

Territory 005 – Jackson and Vermilion Counties

Class Code	\$500,000 / \$1,500,000				
	1	2	3	4	5+
1	5,529	9,636	12,374	13,742	15,111
2	7,582	13,742	17,849	19,903	21,956
3	9,636	17,849	23,325	26,063	28,801
4	11,689	21,956	28,801	32,224	35,646
5	13,742	26,063	34,277	38,384	42,491
6	16,207	30,991	40,848	45,776	50,705
7	17,849	34,277	45,229	50,705	56,180
8	21,217	41,012	54,209	60,807	67,406
9	26,063	50,705	67,132	75,346	83,560
10	30,170	58,918	78,084	87,667	97,249
11	34,277	67,132	89,036	99,987	110,939
12	38,384	75,346	99,987	112,308	124,629
13	42,491	83,560	110,939	124,629	138,318
14	54,811	108,201	143,794	161,591	179,387
15	58,918	116,415	154,746	173,911	193,077

DIVISION OF INSURANCE  
 STATE OF ILLINOIS/IDFPR  
**FILED**  
 MAY 01 2007  
 SPRINGFIELD, ILLINOIS

# 1. Claims-Made Rates by Year (cont.)

Territory 001 - Cook, Madison, St. Clair and Will Counties

Class Code	\$1,000,000 / \$3,000,000				
	1	2	3	4	5+
1	7,317	13,213	17,143	19,109	21,074
2	10,265	19,109	25,004	27,952	30,900
3	13,213	25,004	32,865	36,796	40,726
4	16,161	30,900	40,726	45,639	50,552
5	19,109	36,796	48,587	54,482	60,378
6	22,646	43,870	58,020	65,095	72,169
7	25,004	48,587	64,309	72,169	80,030
8	29,839	58,256	77,200	86,673	96,145
9	36,796	72,169	95,752	107,543	119,334
10	42,691	83,961	111,474	125,230	138,986
11	48,587	95,752	127,195	142,917	158,639
12	54,482	107,543	142,917	160,604	178,291
13	60,378	119,334	158,639	178,291	197,943
14	78,065	154,708	205,804	231,351	256,899
15	83,961	166,499	221,525	249,038	276,551

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson  
Kankakee, Macon, Randolph, Washington and Williamson Counties

Class Code	\$1,000,000 / \$3,000,000				
	1	2	3	4	5+
1	5,549	9,676	12,427	13,803	15,178
2	7,612	13,803	17,930	19,993	22,056
3	9,676	17,930	23,432	26,183	28,935
4	11,739	22,056	28,935	32,374	35,813
5	13,803	26,183	34,437	38,564	42,691
6	16,279	31,136	41,040	45,993	50,945
7	17,930	34,437	45,442	50,945	56,448
8	21,314	41,205	54,467	61,097	67,728
9	26,183	50,945	67,453	75,707	83,961
10	30,310	59,199	78,458	88,088	97,717
11	34,437	67,453	89,463	100,468	111,474
12	38,564	75,707	100,468	112,849	125,230
13	42,691	83,961	111,474	125,230	138,986
14	55,072	108,722	144,489	162,372	180,256
15	59,199	116,976	155,494	174,753	194,012

STATE OF ILLINOIS/IDFPR  
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MAY 01 2007  
SPRINGFIELD, ILLINOIS

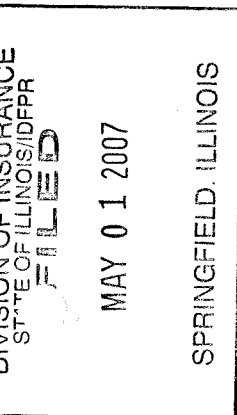
# 1. Claims-Made Rates by Year (cont.)

Territory 003 – Remainder of State

Class Code	\$1,000,000 / \$3,000,000				
	1	2	3	4	5+
1	4,723	8,025	10,226	11,326	12,427
2	6,374	11,326	14,628	16,279	17,930
3	8,025	14,628	19,030	21,231	23,432
4	9,676	17,930	23,432	26,183	28,935
5	11,326	21,231	27,834	31,136	34,437
6	13,307	25,193	33,117	37,079	41,040
7	14,628	27,834	36,638	41,040	45,442
8	17,335	33,249	43,858	49,162	54,467
9	21,231	41,040	54,247	60,850	67,453
10	24,533	47,644	63,051	70,754	78,458
11	27,834	54,247	71,855	80,659	89,463
12	31,136	60,850	80,659	90,564	100,468
13	34,437	67,453	89,463	100,468	111,474
14	44,342	87,262	115,876	130,182	144,489
15	47,644	93,865	124,680	140,087	155,494

Territory 004 – DuPage, Kane, Lake, McHenry and Sangamon Counties

Class Code	\$1,000,000 / \$3,000,000				
	1	2	3	4	5+
1	6,433	11,444	14,785	16,456	18,126
2	8,939	16,456	21,467	23,973	26,478
3	11,444	21,467	28,149	31,490	34,830
4	13,950	26,478	34,830	39,006	43,182
5	16,456	31,490	41,512	46,523	51,535
6	19,462	37,503	49,530	55,544	61,557
7	21,467	41,512	54,875	61,557	68,239
8	25,576	49,731	65,834	73,885	81,936
9	31,490	61,557	81,602	91,625	101,647
10	36,501	71,580	94,966	106,659	118,352
11	41,512	81,602	108,329	121,693	135,056
12	46,523	91,625	121,693	136,726	151,760
13	51,535	101,647	135,056	151,760	168,465
14	66,568	131,715	175,146	196,862	218,577
15	71,580	141,738	188,510	211,896	235,282

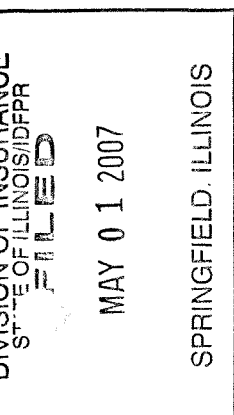




# 1. Claims-Made Rates by Year (cont.)

Territory 005 – Jackson and Vermilion Counties

Class Code	\$1,000,000 / \$3,000,000				
	1	2	3	4	5+
1	6,728	12,034	15,571	17,340	19,109
2	9,381	17,340	22,646	25,299	27,952
3	12,034	22,646	29,721	33,258	36,796
4	14,687	27,952	36,796	41,217	45,639
5	17,340	33,258	43,870	49,176	54,482
6	20,524	39,625	52,360	58,727	65,095
7	22,646	43,870	58,020	65,095	72,169
8	26,997	52,572	69,622	78,148	86,673
9	33,258	65,095	86,319	96,931	107,543
10	38,564	75,707	100,468	112,849	125,230
11	43,870	86,319	114,618	128,767	142,917
12	49,176	96,931	128,767	144,686	160,604
13	54,482	107,543	142,917	160,604	178,291
14	70,401	139,380	185,365	208,358	231,351
15	75,707	149,992	199,515	224,277	249,038



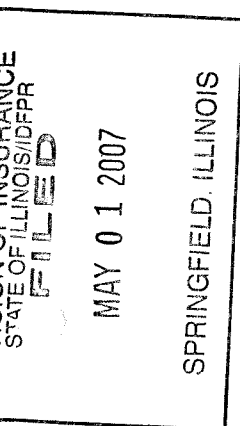
## 2. Extended Reporting Period Endorsement (Tail Coverage)

### Extended Reporting Period (Tail) Factors By Month

Claims-Made  
Year

	1	2	3	4	5	6	7	8	9	10	11	12
1	0.150	0.230	0.310	0.380	0.450	0.520	0.590	0.660	0.730	0.800	0.870	0.940
2	1.010	1.080	1.150	1.220	1.280	1.340	1.400	1.460	1.520	1.580	1.640	1.700
3	1.730	1.760	1.790	1.820	1.850	1.880	1.900	1.920	1.940	1.960	1.980	2.000
4	2.030	2.067	2.100	2.133	2.167	2.200	2.233	2.267	2.300	2.333	2.367	2.400
5	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400

Example: An insured who has a third year claims-made policy and decides to cancel after three months have elapsed would purchase tail coverage at the year 3, three month factor (1.790), times the mature claims-made annual rate in effect at policy issuance. For claims-made year 5 and over the 2.400 factor applies.



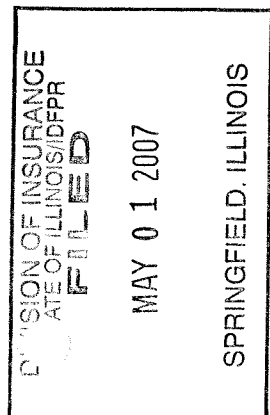
### C. Excess Limits Premium Factors

Excess limits premium shall be derived by applying the appropriate factor below to the appropriate primary rate. Excess limits are only offered above underlying limits of \$1,000,000.

Factors for limits above \$1 Million/\$3 Million Primary:

EXCESS LIMITS	\$1M/\$3M Primary	
	Classes 1 – 8	Classes 9 – 15
\$1M	0.1977	0.2535
\$2M	0.3164	0.4040
\$3M	0.4055	0.5169
\$4M	0.4723	0.6016
\$5M	0.5324	0.6779

These factors are based upon negotiated reinsurance agreements. Deviation from these factors up to 25% based upon negotiated agreements with reinsurers and/or underwriting judgment may apply.



**D. Replacement Coverage Factors for Insurance of Unreported Claims on Previously-Issued Reporting Endorsements or Occurrence Coverage**

Apply the appropriate factor from the tables below to the insured's mature rate for 1M/3M limits.

**1. Factors for Indefinite Reporting Endorsement**

**a) All Specialties other than OB/GYN, Pediatrics or Anesthesiology**

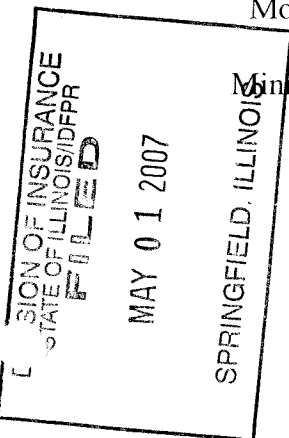
Prior Occurrence Coverage						
Expiration Date or	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
Prior Tail Issue Date	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year+
Up to 1 yr. ago	0.840	1.380	1.680	1.860	1.980	2.040
1+ to 2 yrs. ago	0.540	0.840	1.020	1.140	1.200	1.200
2+ to 3 yrs. ago	0.300	0.480	0.600	0.660	0.660	0.660
3+ to 4 yrs. ago	0.180	0.300	0.360	0.360	0.360	0.360
4+ to 5 yrs. ago	0.120	0.180	0.180	0.180	0.180	0.180
5+ to 6 yrs. ago	0.060	0.060	0.060	0.060	0.060	0.060
More than 6 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

**b) Anesthesiologist Specialty**

Prior Occurrence Coverage						
Expiration Date or	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
Prior Tail Issue Date	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year+
Up to 1 yr. ago	0.600	0.900	1.080	1.140	1.164	1.176
1+ to 2 yrs. ago	0.300	0.480	0.540	0.564	0.576	0.576
2+ to 3 yrs. ago	0.180	0.240	0.264	0.276	0.276	0.276
3+ to 4 yrs. ago	0.060	0.084	0.096	0.096	0.096	0.096
4+ to 5 yrs. ago	0.024	0.036	0.036	0.036	0.036	0.036
5+ to 6 yrs. ago	0.012	0.012	0.012	0.012	0.012	0.012
More than 6 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

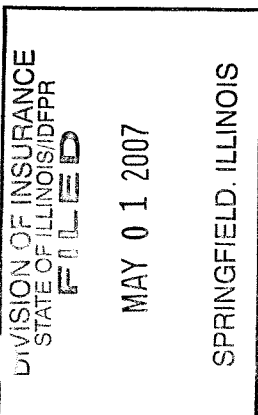


c) OB/GYN and Pediatric Specialties

Prior Occurrence  
Coverage

Expiration Date or	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
Prior Tail Issue Date	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year
Up to 1 yr. ago	0.720	1.260	1.620	1.800	1.920	2.016
1+ to 2 yrs. ago	0.540	0.900	1.080	1.200	1.296	1.368
2+ to 3 yrs. ago	0.360	0.540	0.660	0.756	0.828	0.876
3+ to 4 yrs. ago	0.180	0.300	0.396	0.468	0.516	0.552
4+ to 5 yrs. ago	0.120	0.216	0.288	0.336	0.372	0.396
5+ to 6 yrs. ago	0.096	0.168	0.216	0.252	0.276	0.288
6+ to 7 yrs. ago	0.072	0.120	0.156	0.180	0.192	0.192
7+ to 8 yrs. ago	0.048	0.084	0.108	0.120	0.120	0.120
8+ to 9 yrs. ago	0.036	0.060	0.072	0.072	0.072	0.072
9+ to 10 yrs. ago	0.024	0.036	0.036	0.036	0.036	0.036
10+ to 11 yrs. ago	0.012	0.012	0.012	0.012	0.012	0.012
More than 11 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000
		7th Year	8th Year	9th Year	10th Year	11th Year+
Up to 1 yr. ago		2.088	2.136	2.172	2.196	2.208
1+ to 2 yrs. ago		1.416	1.452	1.476	1.488	1.488
2+ to 3 yrs. ago		0.912	0.936	0.948	0.948	0.948
3+ to 4 yrs. ago		0.576	0.588	0.588	0.588	0.588
4+ to 5 yrs. ago		0.408	0.408	0.408	0.408	0.408
5+ to 6 yrs. ago		0.288	0.288	0.288	0.288	0.288
6+ to 7 yrs. ago		0.192	0.192	0.192	0.192	0.192
7+ to 8 yrs. ago		0.120	0.120	0.120	0.120	0.120
8+ to 9 yrs. ago		0.072	0.072	0.072	0.072	0.072
9+ to 10 yrs. ago		0.036	0.036	0.036	0.036	0.036
10+ to 11 yrs. ago		0.012	0.012	0.012	0.012	0.012
More than 11 yrs. ago		0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.



## 2. Factors for Annually Renewed Prior Occurrence and Tail Replacement Coverage

This option is intended to allow the policyholder the choice of a shorter reporting period at a lesser premium than charged for the indefinite period and an effectively longer payment plan than otherwise offered. It is not intended to allow the Company the option to refuse to extend the reporting period at any given year. If the insured elects to renew a sufficient number of times (seven for OB/GYN and Pediatrics and four for all other specialties), this coverage will convert from an annually renewing reporting period to an indefinite reporting period.

### a) All Specialties other than OB/GYN, Pediatrics or Anesthesiology

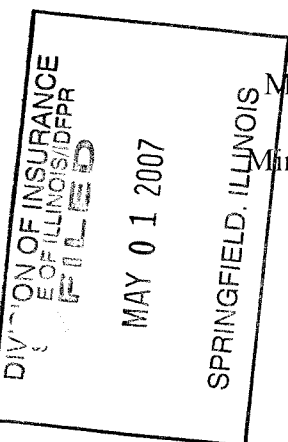
Occurrence Coverage End Date or Tail Issue Date	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
	1st Year	2nd Year	3rd Year	4 <sup>th</sup> Year	5th Year	6th Year+
Up to 1 yr. ago	0.275	0.495	0.605	0.660	0.715	0.770
1+ to 2 yrs. ago	0.220	0.330	0.385	0.440	0.495	0.495
2+ to 3 yrs. ago	0.110	0.165	0.220	0.275	0.275	0.275
3+ to 4 yrs. ago	0.055	0.110	0.165	0.165	0.165	0.165
4+ to 5 yrs. ago	0.055	0.110	0.110	0.110	0.110	0.110
5+ to 6 yrs. ago	0.055	0.055	0.055	0.055	0.055	0.055
More than 6 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.

### b) Anesthesiologist Specialty

Occurrence Coverage End Date or Tail Issue Date	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year+
Up to 1 yr. ago	0.275	0.385	0.495	0.528	0.539	0.550
1+ to 2 yrs. ago	0.110	0.220	0.253	0.264	0.275	0.275
2+ to 3 yrs. ago	0.110	0.143	0.154	0.165	0.165	0.165
3+ to 4 yrs. ago	0.033	0.044	0.055	0.055	0.055	0.055
4+ to 5 yrs. ago	0.011	0.022	0.022	0.022	0.022	0.022
5+ to 6 yrs. ago	0.011	0.011	0.011	0.011	0.011	0.011
More than 6 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000

Minimum factor to apply: .07.



c) OB/GYN and Pediatric Specialties

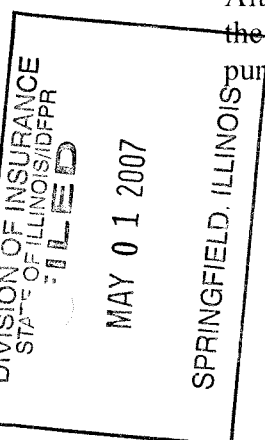
Occurrence Coverage End Date or Tail Issue Date	C-M Maturity or Years of Occurrence Coverage Year at Time of Prior Tail Issuance					
	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year
	Up to 1 yr. ago	1+ to 2 yrs. ago	2+ to 3 yrs. ago	3+ to 4 yrs. ago	4+ to 5 yrs. ago	5+ to 6 yrs. ago
Up to 1 yr. ago	0.165	0.330	0.495	0.550	0.572	0.594
1+ to 2 yrs. ago	0.165	0.330	0.385	0.407	0.429	0.451
2+ to 3 yrs. ago	0.165	0.220	0.242	0.264	0.286	0.297
3+ to 4 yrs. ago	0.055	0.077	0.099	0.121	0.132	0.143
4+ to 5 yrs. ago	0.022	0.044	0.066	0.077	0.088	0.099
5+ to 6 yrs. ago	0.022	0.044	0.055	0.066	0.077	0.088
6+ to 7 yrs. ago	0.022	0.033	0.044	0.055	0.066	0.066
7+ to 8 yrs. ago	0.011	0.022	0.033	0.044	0.044	0.044
8+ to 9 yrs. ago	0.011	0.022	0.033	0.033	0.033	0.033
9+ to 10 yrs. ago	0.011	0.022	0.022	0.022	0.022	0.022
10+ to 11 yrs. ago	0.011	0.011	0.011	0.011	0.011	0.011
More than 11 yrs. ago	0.000	0.000	0.000	0.000	0.000	0.000
	7th Year	8th Year	9th Year	10th Year	11th Year+	
Up to 1 yr. ago	0.616	0.627	0.638	0.649	0.660	
1+ to 2 yrs. ago	0.462	0.473	0.484	0.495	0.495	
2+ to 3 yrs. ago	0.308	0.319	0.330	0.330	0.330	
3+ to 4 yrs. ago	0.154	0.165	0.165	0.165	0.165	
4+ to 5 yrs. ago	0.110	0.110	0.110	0.110	0.110	
5+ to 6 yrs. ago	0.088	0.088	0.088	0.088	0.088	
6+ to 7 yrs. ago	0.066	0.066	0.066	0.066	0.066	
7+ to 8 yrs. ago	0.044	0.044	0.044	0.044	0.044	
8+ to 9 yrs. ago	0.033	0.033	0.033	0.033	0.033	
9+ to 10 yrs. ago	0.022	0.022	0.022	0.022	0.022	
10+ to 11 yrs. ago	0.011	0.011	0.011	0.011	0.011	
More than 11 yrs. ago	0.000	0.000	0.000	0.000	0.000	

Minimum factor to apply: .07.

3. Group Discount Factor

After calculating each insured's preliminary rate for the Replacement Coverage, apply the factor from the table below which corresponds to the number of insureds in the group for whom the coverage is purchased.

# of Physicians	Discount Factor
1	1.000
2-3	0.970
4-6	0.950
7-10	0.925
11-20	0.900
Over 20	0.850



## II. STATE EXCEPTIONS

### A. Policy Issuance

### B. Rules

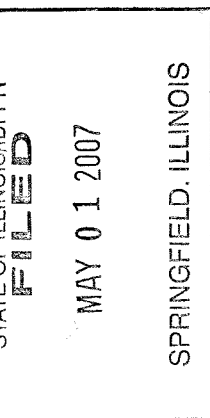
1. Section 2, Physicians & Surgeons Specialty Codes and Descriptions, is amended by adding the following:

<u>Specialty</u>	<u>Industry Class Code</u>		
	<u>No Surgery</u>	<u>Minor Surgery</u>	<u>Major Surgery</u>
Endocrinology	80238	-	-
Infectious Disease	80246	-	-

2. Section 2, Physicians & Surgeons Specialty Codes and Descriptions, is amended by adding the following:

### CLARIFICATION OF SPECIALTY CODES

<u>Code</u>	<u>Specialty Description</u>
80102(A)	Emergency Medicine – Moonlighting - no surgery
80102(B)	Emergency Medicine – Moonlighting - minor surgery
80102(C)	Emergency Medicine – clinic/hosp. primarily
80117(A)	Family/General Practice, No OB – major surgery
80117(B)	Family/General Practice, Limited OB – major surgery
80117(C)	Family/General Practice, Significant OB – major surgery
80145(A)	Urology – no surgery
80145(B)	Urology – minor surgery
80145(C)	Urology – major surgery
80154(A)	Orthopedic (No Spines) – major surgery
80154(B)	Orthopedic (Spines) – major surgery
80222(A)	Hospitalist – Hosp. Employed/ Single Hospital Affiliation
80222(B)	Hospitalist – Non-Hosp. Employed/Multiple Hospital Affiliations
80256(A)	Dermatology – no surgery
80256(B)	Dermatology – no surgery (specified procedures)
80281(A)	Cardiovascular Dis. – minor surgery
80281(B)	Cardiovascular Dis. – minor surgery, specified procedures
80421(A)	FP or GP – assist in major surgery - own patients only (no minor)
80421(B)	FP or GP – minor surgery & assist in major surgery- own patients
80421(C)	FP or GP – assist in major surgery
80424(F)	Urgent Care – no surgery
80424(V)	Urgent Care – no surgery, rated on a per-visit basis
80475(A)	Pain Management – no major surgery
80475(B)	Pain Management – basic procedures
80475(C)	Pain Management – intermediate procedures
80475(D)	Pain Management – advanced procedures
80116(A)	Physician Assistant
80116(B)	Surgeon Assistant
80960(D)	Nurse Anesthetist – Dental
80960(M)	Nurse Anesthetist – Medical





3. Item C, Reporting Endorsement Coverage of Section 3, Classification and/or Rating Modifications and Procedures, part VIII. Rate Adjustments for Changes in Exposure -- Claims-Made, Retroactive, and Reporting Endorsement Coverage, is replaced by:

The calculations for changes in exposure are performed by weighting the mature claims-made annual rates in effect at policy issuance for each period of differing exposures. These calculations are appropriate for changes in practice specialty or changes in rating territory that would affect a calculated rate. This method can be generalized by using the following weights and formula to calculate a rate for the upcoming year.

Number of years policy written	Claims-Made Year				
	1	2	3	4	5+
1	100%				
2	50%	50%			
3	37.5%	37.5%	25%		
4	33 1/3%	33 1/3%	22 2/9%	11 1/9%	
5+	30%	30%	20%	10%	10%

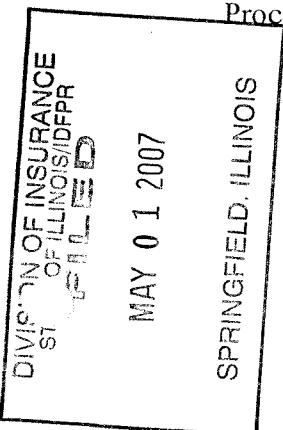
1. Mature claims-made annual rate in effect at policy issuance for the current practice and territory times the sum of the weights for the claims-made years in effect.
2. Plus mature claims-made annual rate in effect at policy issuance for the prior practice and territory times the sum of the weights for the claims-made years in effect.

For example, if a physician had practiced obstetrics and gynecology for over five years, then stopped practicing obstetrics and began to practice gynecology at the renewal two years prior to the electing the Reporting Endorsement Coverage, the appropriate base premium for the upcoming policy period would be:

Gynecology mature claims-made annual rate in effect at policy issuance times (30% + 30%), plus OB/GYN mature claims-made annual rate in effect at policy issuance times (20% + 10 % + 10%)

This method is applied in a similar manner if more than one practice change occurred during the previous four years. The components are pro-rated if the change occurred at a date other than the policy anniversary date.

4. Item X, Rate Change Amelioration, of Section 3, Classification and/or Rating Modifications and Procedures, is hereby deleted.



5. Item V, Scheduled Rating Program, of Section 4, Professional Liability Discounts, is amended as follows:

## V. SCHEDULED RATING PROGRAM

The Company has determined that significant variability exists in the hazards faced by physicians and surgeons engaged in the practice of medicine. Exposure conditions vary with respect to:

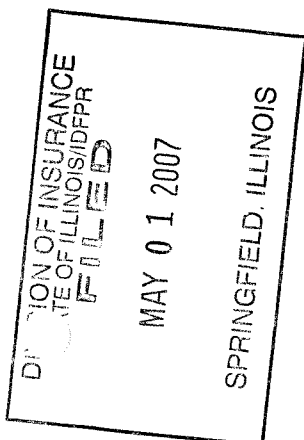
	<u>Debit/Credit</u>
1. Number of years experience in medicine;	+/- 10%
2. Number of patient exposures;	+/- 10%
3. Organization (if any) and size;	+/- 10%
4. Medical standards review and claims review committees;	+/- 10%
5. Other risk management practices and procedures;	+/- 10%
6. Training, accreditation and credentialing;	+/- 10%
7. Continuing Medical Education activities;	+/- 10%
8. Professional liability claim experience;	+/- 10%
9. Record-keeping practices;	+/- 10%
10. Maintenance and utilization of certain monitoring equipment, diagnostic tests or diagnostic procedures;	+/- 10%
11. Participation in capitation contracts; and*	+ 10%
12. Insured group maintains differing limits of liability on members.*	+ 10%

In order to recognize these and other factors affecting a particular practitioner or group practice, the Company proposes to apply a debit or credit to the otherwise applicable rate dependent upon the underwriter's overall evaluation of the risk.

The maximum credit will be 25%; the maximum debit will be 25%.

The Scheduled Rating Plan will apply to individuals as well as groups of two or more physicians as the Company becomes aware of variability in the risk characteristics of the individual or group. At the underwriter's discretion, objective credits otherwise applicable to an insured will not be applied in situations where a scheduled debit is deemed necessary.

\* NOTE: No credit will be given for #11 or #12 above.



6. Item VI, Deductibles, of Section 4, Professional Liability Discounts, is hereby replaced by the following:

## VI. DEDUCTIBLES

Deductibles may apply either to indemnity only or indemnity and allocated loss adjustment expenses (ALAE). Any discount will apply only to the primary limit premium layer (\$1M/\$3M). Deductibles are subject to approval by the company based on financial statements to be submitted by the insured and financial guarantees as required. The amount of the deductible credit may never exceed 80% of the annual aggregate, if any. In the event where the credit exceeds 80% of the aggregate, the annual aggregate will be adjusted accordingly. This Rule does not apply to any risk when a deductible has been added for underwriting reasons.

### A. Individual Deductibles

#### Discount as a Percentage of Rate for Applicable Primary Limit

These per claim and aggregate (if any) deductibles apply to each insured separately.

#### INDEMNITY ONLY Deductible Per Claim

\$ 5,000	2.5%
\$10,000	4.5%
\$15,000	6.0%
\$20,000	8.0%
\$25,000	9.0%
\$50,000	15.0%
\$100,000	25.0%
\$200,000	37.5%
\$250,000	42.0%

#### INDEMNITY AND ALAE Deductible Per Claim

\$ 5,000	6.5%
\$10,000	11.5%
\$15,000	15.0%
\$20,000	17.5%
\$25,000	20.0%
\$50,000	30.5%
\$100,000	44.5%
\$200,000	55.0%
\$250,000	58.0%

#### Per Claim/Aggregate

\$ 5,000/15,000	2.0%
\$10,000/30,000	4.0%
\$25,000/75,000	8.5%
\$50,000/150,000	14.0%
\$100,000/300,000	24.0%
\$200,000/600,000	36.0%
\$250,000/750,000	40.0%

#### Per Claim/Aggregate

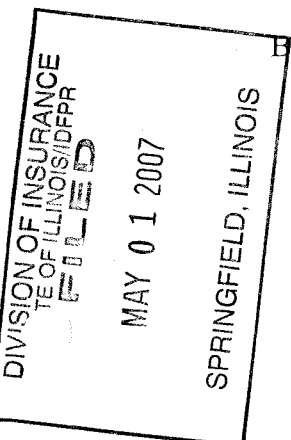
\$ 5,000/15,000	5.5%
\$10,000/30,000	10.5%
\$25,000/75,000	19.0%
\$50,000/150,000	29.5%
\$100,000/300,000	43.0%
\$200,000/600,000	53.5%
\$250,000/750,000	56.5%

For other deductible amounts selected by policyholders, refer to management for rating.

### B. Group Deductibles

An optional deductible which limits the amount the entire group will have to pay, if multiple claims are made in a policy year, is available. Under this program, the per claim deductible continues to apply separately to each insured involved in a suit. However, the aggregate deductible applies to all insureds in the group combined thereby reducing the organization's maximum potential liability in a policy year.

When an organization is insured with a separate limit of coverage, the organization is counted when totaling the number of insureds below.



Group aggregate deductible discounts apply to \$1M/\$3M premiums only. The applicable Deductible Discount will not change during the policy term despite changes in the number of insureds, but will be limited by any applicable maximum credit amount.

**Indemnity Deductible**

Per Claim/Aggregate (\$000)	Number of Insureds				Maximum Credit
	2 - 19	20 - 40	41 - 60	61 - 100	
5/15	.020	.018	.015	.012	\$ 10,500
10/30	.038	.035	.030	.024	21,000
25/75	.084	.079	.070	.058	52,500
50/150	.145	.139	.127	.109	105,000
100/300	.234	.228	.216	.196	210,000
200/600	.348	.346	.338	.321	420,000
250/750	.385	.385	.381	.368	525,000

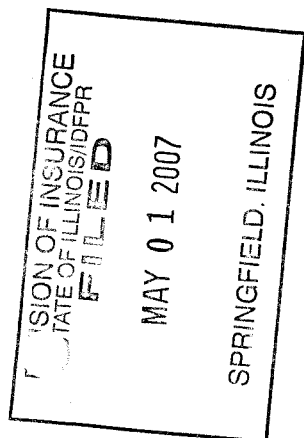
**Indemnity & ALAE  
Deductible**

Per Claim/Aggregate (\$000)	Number of Insureds				Maximum Credit
	2 - 19	20 - 40	41 - 60	61 - 100	
5/15	.029	.026	.021	.017	\$ 12,750
10/30	.068	.063	.054	.043	25,500
25/75	.119	.112	.099	.082	63,750
50/150	.186	.179	.163	.140	127,500
100/300	.258	.252	.239	.216	255,000
200/600	.396	.394	.385	.366	510,000
250/750	.467	.467	.462	.446	637,500

7. Section 4, Professional Liability Discounts, is hereby amended by adding the following:

**VIII. ANNUAL PREMIUM PAYMENT DISCOUNT**

A discount of 1.5% of the policy premium will be applied if the insured pays the premium in full prior to the inception date of the policy. This discount is not available if the initial policy term is less than six months. If the full premium is not received by the Company by the policy effective date, the discount will be withdrawn, the policy will be rated without the discount and the insured will be billed for the additional premium.



### III. STATE REQUIREMENTS

#### A. Policy Issuance

1. The Illinois State Law Endorsement must be attached to the policy at the time of issuance.
2. Item III, Quarterly Installment Options, is hereby added to Section 1, Introduction, as follows:

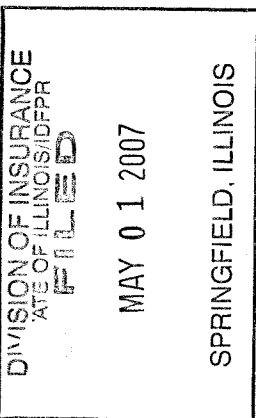
#### III. QUARTERLY INSTALLMENT OPTIONS

1. Quarterly Installment Option One
  - a. A minimum initial deposit required, which shall be 40 percent of the estimated total premium due at policy inception;
  - b. The remaining premium spread equally among the second, third and fourth installments at 20 percent of the estimated total premium, and due 3, 6 and 9 months from policy inception, respectively;
  - c. No interest or installment charges;
  - d. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to the policy shall be billed immediately as a separate transaction; and
  - e. The installment plan will be limited to insureds whose premium exceeds \$500.00 per year.
2. Quarterly Installment Option Two – (35/25/25/15)
  - a. A minimum initial deposit required, which shall be 35 percent of the estimated total premium due at policy inception;
  - b. The remaining premium will be 25 percent for the second and third installments and 15 percent for the fourth installment, and due 3, 6 and 9 months from policy inception, respectively;
  - c. No interest or installment charges;
  - d. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to the policy shall be billed immediately as a separate transaction; and
  - e. The installment plan will be limited to insureds whose premium exceeds \$500.00 per year.

#### B. Rules

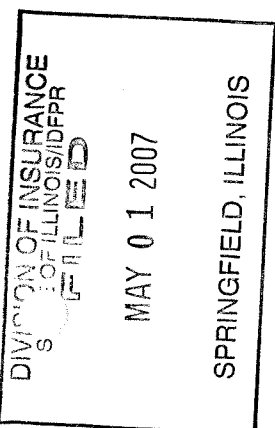
1. Item I, Rates and Premium Calculations, of Section 1, Introduction, is hereby amended.

A. Rates apply on a per incident and annual aggregate basis. The rates for the premium classifications selected by the Company or any special situations not delineated herein are those described in the Professional Liability State Rates and Exceptions Section of this manual, with a minimum premium being \$500 (not applicable to paramedicals). If an individual's practice involves two or more rating territories or rating classifications, the highest rating territory or classification applies. Endorsements adding risks/exposures mid-term will be rated in accordance with the Rates and Rules in effect as of the endorsement effective date. Subject to Section 3., VIII, (Rate Adjustments for Changes in Exposure) of this manual, Reporting Endorsements will be rated in accordance with the Rates and Rules in effect as of the policy effective date. Subject to Section 3, VIII, (Rate Adjustments for Changes in Exposure) of this manual, endorsements effecting changes on risks/exposures currently insured will be rated using the Rules (e.g., rating classification, limits of liability and rating territory) in effect on the date of the change combined with the rates in effect on the later date of either i) the policy term effective date or ii) risk effective date.



2. Item IX, Reporting Endorsements, of Section 3, Classification and/or Rating Modifications and Procedures, is hereby amended.

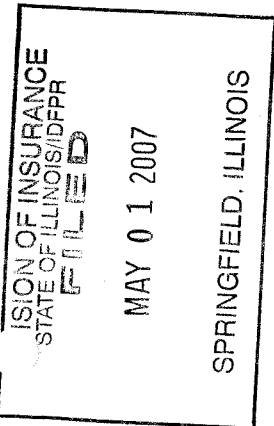
With respect to calculation of Reporting Endorsement premium, the only credits/discounts that apply are the Part-Time discount and Deductible credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. With respect to risks or exposures written on a consent-to-rate basis, (a) rated basis or Full-Time Equivalent Rating basis at the time the Reporting Endorsement is issued, Reporting Endorsement premium will be calculated on that same basis. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.



**CorpCare™**

**SECTION 10**

**STATE RATES AND EXCEPTIONS – GROUPS**



## I. RATES

### A. Per Patient Rates – Emergency Room / Urgent Care

1. Rating of Emergency Room and Urgent Care Groups may, at the Company's option be rated on a per 100 patient visit basis. A risk with fewer than 10,000 patient encounters each year will not qualify for this rating method.
2. For risks rated on a per patient basis, develop premium using the following per100 patient visit rates. The above rates are subject to increased limit factors and standard CorpCare™ rating factors.

<b>Claims-made Rate Per 100 Patient Visits \$1,000,000 / \$3,000,000</b>						
<b>Class</b>	<b>Code</b>	<b>Territory 1</b>	<b>Territory 2</b>	<b>Territory 3</b>	<b>Territory 4</b>	<b>Territory 5</b>
Emergency Room	80429	\$2,287	\$1,613	\$1,298	\$1,950	\$2,062
Urgent Care	80424(V)	\$1,725	\$1,220	\$984	\$1,472	\$1,557

3. Extended Reporting Endorsement Period Endorsement (Tail Coverage)

#### Extended Reporting Period (Tail) Factors By Month

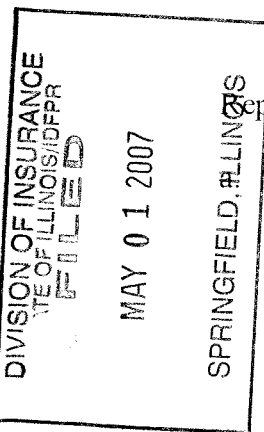
##### Claims-Made Year

	1	2	3	4	5	6	7	8	9	10	11	12
1	0.150	0.230	0.310	0.380	0.450	0.520	0.590	0.660	0.730	0.800	0.870	0.940
2	1.010	1.080	1.150	1.220	1.280	1.340	1.400	1.460	1.520	1.580	1.640	1.700
3	1.730	1.760	1.790	1.820	1.850	1.880	1.900	1.920	1.940	1.960	1.980	2.000
4	2.030	2.067	2.100	2.133	2.167	2.200	2.233	2.267	2.300	2.333	2.367	2.400
5	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400

Example: An insured who has a third year claims-made policy and decides to cancel after three months have elapsed would purchase tail coverage at the year 3, three month factor (1.790), times the mature claims-made annual rate in effect at policy issuance. For claims-made year 5 and over the 2.400 factor applies.

#### Reporting Endorsement ("Tail") Premium Development

Determine the tail premium for each current scheduled health care provider, if applicable. See Section 9, State Rates and Exceptions - Physicians, Surgeons and Podiatrists - Extended Reporting Period Endorsement (Tail Coverage). The only credits/discounts that apply are the Part-Time discount and Deductible credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.

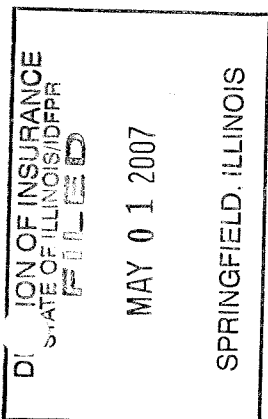




- b. For per patient rated risks, use average number of patient visits for the previous thirty-six months. The only credit/discount that applies is the Deductible credit. All debit/surcharges will apply to Reporting Endorsement premium calculations. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.
- c. Determine the remaining optional separate limit premium, if applicable.
- d. Add premiums determined in Steps a., b. and c. to determine total policy premium.

## B. Rating Territories

<b>Territory</b>	<b>County</b>
1	Cook, Madison, St. Clair and Will Counties
2	Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson, Kankakee, Macon, Randolph, Washington and Williamson Counties
3	Remainder of State
4	DuPage, Kane, Lake, McHenry and Sangamon Counties
5	Jackson and Vermilion Counties



## II. STATE EXCEPTIONS

### A. Policy Issuance

### B. Rules

1. Item X, Rate Change Amelioration, of Section 3, Classification and/or Rating Modifications and Procedures, is hereby deleted.
2. Item C. Reporting Endorsement Coverage of Section 3, Classification and/or Rating Modifications and Procedures, part VIII. Rate Adjustments for Changes in Exposure -- Claims-Made, Retroactive, and Reporting Endorsement Coverage, is replaced by:

The calculations for changes in exposure are performed by weighting the mature claims-made annual rates in effect at policy issuance for each period of differing exposures. These calculations are appropriate for changes in practice specialty or changes in rating territory that would affect a calculated rate. This method can be generalized by using the following weights and formula to calculate a rate for the upcoming year.

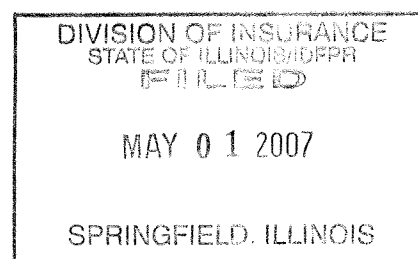
Number of years policy written	Claims-Made Year				
	1	2	3	4	5+
1	100%				
2	50%	50%			
3	37.5%	37.5%	25%		
4	33 1/3%	33 1/3%	22 2/9%	11 1/9%	
5+	30%	30%	20%	10%	10%

1. Mature claims-made annual rate in effect at policy issuance for the current practice and territory times the sum of the weights for the claims-made years in effect.
2. Plus mature claims-made annual rate in effect at policy issuance for the prior practice and territory times the sum of the weights for the claims-made years in effect.

For example, if a physician had practiced obstetrics and gynecology for over five years, then stopped practicing obstetrics and began to practice gynecology at the renewal two years prior to the electing the Reporting Endorsement Coverage, the appropriate base premium for the upcoming policy period would be:

Gynecology mature claims-made annual rate in effect at policy issuance times (30% + 30%),  
plus OB/GYN mature claims-made annual rate in effect at policy issuance times (20% + 10% + 10%)

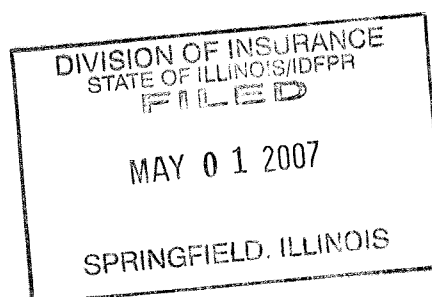
This method is applied in a similar manner if more than one practice change occurred during the previous four years. The components are pro-rated if the change occurred at a date other than the policy anniversary date.



3. Section 4, Professional Liability Discounts, is hereby amended by adding the following:

**VIII. ANNUAL PREMIUM PAYMENT DISCOUNT**

A discount of 1.5% of the policy premium will be applied if the insured pays the premium in full prior to the inception date of the policy. This discount is not available if the initial policy term is less than six months. If the full premium is not received by the Company by the policy effective date, the discount will be withdrawn, the policy will be rated without the discount and the insured will be billed for the additional premium.



### III. STATE REQUIREMENTS

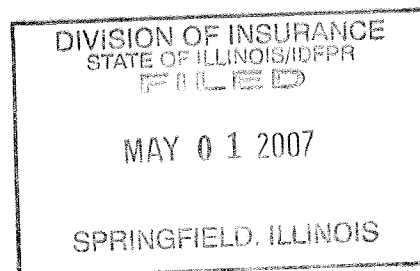
#### A. Policy Issuance

1. The Illinois State Law Endorsement must be attached to the policy at the time of issuance.
2. Item III, Quarterly Installment Options, is hereby added to Section I, Introduction, as follows:

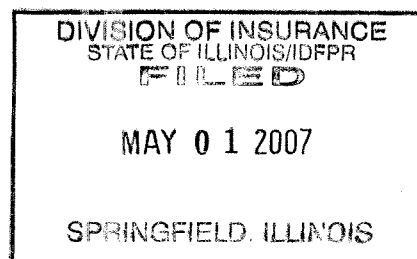
#### III. QUARTERLY INSTALLMENT OPTIONS

1. Quarterly Installment Option One – (40/20/20/20)
  - a. A minimum initial deposit required, which shall be 40 percent of the estimated total premium due at policy inception;
  - b. The remaining premium spread equally among the second, third and fourth installments at 20 percent of the estimated total premium, and due 3, 6 and 9 months from policy inception, respectively;
  - c. No interest or installment charges;
  - d. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to the policy shall be billed immediately as a separate transaction; and
  - e. The installment plan will be limited to insureds whose premium exceeds \$500.00 per year.
2. Quarterly Installment Option Two – (35/25/25/15)
  - a. A minimum initial deposit required, which shall be 35 percent of the estimated total premium due at policy inception;
  - b. The remaining premium will be 25 percent for the second and third installments and 15 percent for the fourth installment, and due 3, 6 and 9 months from policy inception, respectively;
  - c. No interest or installment charges;
  - d. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to the policy shall be billed immediately as a separate transaction; and
  - e. The installment plan will be limited to insureds whose premium exceeds \$500.00 per year.

#### B. Rules



**SECTION 11**  
**STATE RATES AND EXCEPTIONS – PHYSICIAN EXTENDER, PARAMEDICAL**  
**AND**  
**ALLIED HEALTH PROFESSIONAL LIABILITY RATING**



## I. STATE EXCEPTIONS

### A. Policy Issuance

### B. Rules

1. Item X, Amelioration, of Section 3, Classification and/or Rating Modifications and Procedures, is hereby deleted.
2. Item C. Reporting Endorsement Coverage of Section 3, Classification and/or Rating Modifications and Procedures, part VIII. Rate Adjustments for Changes in Exposure -- Claims-Made, Retroactive, and Reporting Endorsement Coverage, is replaced by:

The calculations for changes in exposure are performed by weighting the mature claims-made annual rates in effect at policy issuance for each period of differing exposures. These calculations are appropriate for changes in practice specialty or changes in rating territory that would affect a calculated rate. This method can be generalized by using the following weights and formula to calculate a rate for the upcoming year.

Number of years policy written	Claims-Made Year				
	1	2	3	4	5+
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2	50%	50%			
3	37.5%	37.5%	25%		
4	33 1/3%	33 1/3%	22 2/9%	11 1/9%	
5+	30%	30%	20%	10%	10%

1. Mature claims-made annual rate in effect at policy issuance for the current practice and territory times the sum of the weights for the claims-made years in effect.
2. Plus mature claims-made annual rate in effect at policy issuance for the prior practice and territory times the sum of the weights for the claims-made years in effect.

For example, if a physician had practiced obstetrics and gynecology for over five years, then stopped practicing obstetrics and began to practice gynecology at the renewal two years prior to the electing the Reporting Endorsement Coverage, the appropriate base premium for the upcoming policy period would be:

Gynecology mature claims-made annual rate in effect at policy issuance times (30% + 30%),  
plus OB/GYN mature claims-made annual rate in effect at policy issuance times (20% + 10 % + 10%)

This method is applied in a similar manner if more than one practice change occurred during the previous four years. The components are pro-rated if the change occurred at a date other than the policy anniversary date.

Section 4, Professional Liability Discounts, is hereby amended by adding the following:

### III. ANNUAL PREMIUM PAYMENT DISCOUNT

A discount of 1.5% of the policy premium will be applied if the insured pays the premium in full prior to the inception date of the policy. This discount is not available if the initial policy term is less than six months. If the full premium is not received by the Company by the policy effective date, the discount will be withdrawn, the policy will be rated without the discount and the insured will be billed for the additional premium.

DIVISION OF INSURANCE  
STATE OF ILLINOIS/IDFPR

FILED

MAY 01 2007

SPRINGFIELD, ILLINOIS

- 3 Item I of Section 6, Physician Extender, Paramedical and Allied Health Professional Liability Rating, is hereby amended as follows:

**I. PHYSICIAN EXTENDER, AND PARAMEDICAL EMPLOYEES, ALLIED HEALTH EMPLOYEE PROFESSIONAL LIABILITY**

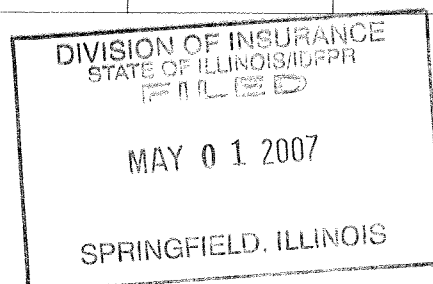
Professional employees (other than cytotechnologists, dentists, emergency medical technicians, certified registered nurse anesthetists, nurse midwives, nurse practitioners, optometrists, perfusionists, physicians, physicians' assistants, psychologists, surgeons or surgeons' assistants) are automatically included, at no additional charge, as additional insureds under policies issued to their employers. The limits of liability are on a shared basis with the employer.

The following paramedical employees may be individually covered by the Company by payment of an additional premium or covered elsewhere through a program deemed acceptable to the Company with minimum limits of liability equal to or greater than those of the insured employer. Coverage is available on a shared-limits basis or with separate individual limits. To determine the additional premium for the coverage selected, apply the appropriate factor from the premium assigned to Physician Class Codes 80420, 80151, 80153, 80266 or 80114, as specified, for the applicable claims-made year and limits of liability.

(Paramedical employees written on a shared-limits basis will be charged a fourth year claims-made premium regardless of retroactive date and the shared-limits factors stated above will always be applied to a fourth year claims-made premium.)

Employee	(Factors based on 80420)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Physician's Assistant (PA)	0.027	0.083	0.025
Surgeon's Assistant (SA)	0.041	0.124	0.037
Certified Nurse Practitioner (CNP)	0.045	0.138	0.041
Psychologist	0.040	0.050	0.015
Emergency Medical Technician (EMT)	0.004	0.010	0.003
Perfusionist	0.166	0.500	0.149

Employee	(Factors based on 80151)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Anesthetist (CRNA) – not part of an insured group	N/A	0.420	0.126
CRNA employed by an insured group - separate limits basis	N/A	0.300	0.090
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists between 2:1 and 4:1	0.180	N/A	N/A
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists no more than 2:1	0.090	N/A	N/A



For CRNAs employed by an insured performing pain management procedures, apply the above factor to the 80475(C) ISO code and applicable rate class.

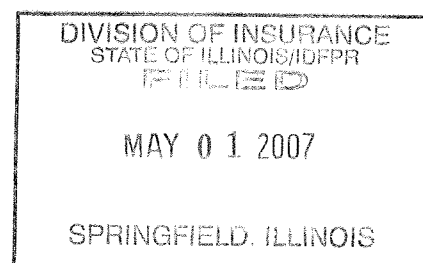
(If the ratio of employed CRNA's to Anesthesiologists exceeds 4-to-1, the Company may decline to insure the risk, or apply an additional premium, at its sole discretion.)

Employee	(Factors based on 80153)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Midwife (CNM)	0.129	0.388	0.116

Employee	(Factors based on 80266)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Cytotechnologist	0.100	N/A	N/A

Employee	(Factors based on 80114)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Optometrist	0.020	0.040	0.012

**NOTE:** When the limits of liability apply on a shared basis with the physicians of the group, the premium charge for the excess limits for the paramedical employees will be calculated at the level that the majority of physicians carry.



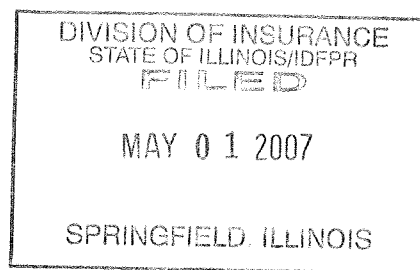


4. Item II of Section 6, Physician Extender, Paramedical and Allied Health Professional Liability Rating, is hereby amended as follows:

## II. ALLIED HEALTH PROFESSIONAL EMPLOYEES

Certain Allied Health professionals are eligible for separate insurance by the Company at individual limits of liability. The premium charge will be determined by applying the factors below to the appropriate rate for the designated Physician Class Code in the applicable rating territory.

SPECIALTY	CLASS CODE	\$1M/\$3M (Factors based on 80420)
Audiologist	80760	0.018
Cardiac Technician	80751	0.025
Casting Technician	80752	0.020
Certified Nurse Practitioner	80964	0.138
Clinical Nurse Specialist	80964	0.400
Counselor	80712	0.045
Dietitian	89761	0.018
EKG Technician	80763	0.018
Medical Assistant	80762	0.018
Medical Lab Technician	80711	0.018
Nurse	80998	0.018
Nurse – Student	82998	0.005
Nurse, RN Perform X-Ray Therapy	80714	0.018
Occupational Therapist	80750	0.025
O.R. Technician	80758	0.125
Ophthalmic Assistant	80755	0.018
Orthopedic Technician	80756	0.020
Perfusionist	80764	0.500
Pharmacist	59112	0.025
Phlebotomist	80753	0.018
Physical Therapist (Emp)	80945	0.025
Physical Therapist (Ind)	80946	0.090
Physical Therapy Aide	80995	0.018
Physician Assistant	80116(A)	0.083
Physiotherapist	80938	0.018
Psychologist	80912	0.050
Pump Technician	88888	0.020
Respiratory Therapist	80601	0.025
Social Worker	80911	0.045
Sonographer	80754	0.018
Surgeon Assistant	80116(B)	0.124
X-Ray/Radiologic Technician	80713	0.018
X-Ray Therapy Technician	80716	0.025
		(Factors based on 80211)
Dental Assistant	80207	0.100
Dental Hygienist	80208	0.100
Nurse Anesthetist – Dental	80960(D)	4.306



SPECIALTY	CLASS CODE	\$1M/\$3M
Nurse Anesthetist – Medical	80960(M)	(Factors based on 80151) 0.420
Optometrist (Optical)	80944	(Factors based on 80114) 0.032
Optometrist (Employee*)	80944	**See note below
Optometrist (Independent**)	80944	**See note below

\*25% of an Ophthalmologists base premium. (If administering topical ocular pharmaceutical agents.)

\*\*75% of an Ophthalmologists base premium. (If administering topical ocular pharmaceutical agents.)

Health Care Professional NOC	80301	Refer to Company
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At the discretion of the underwriter, additional insured status may be granted to the non-insured allied health entity for a 10% additional charge. The entity will share in the limits of liability of the insured allied health provider but only for the activities of such provider.

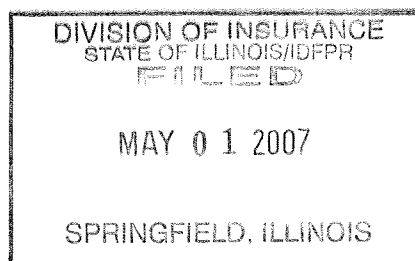
### C. Extended Reporting Period Endorsement (Tail Coverage)

#### Extended Reporting Period (Tail) Factors By Month

##### Claims-Made Year

	1	2	3	4	5	6	7	8	9	10	11	12
1	0.150	0.230	0.310	0.380	0.450	0.520	0.590	0.660	0.730	0.800	0.870	0.940
2	1.010	1.080	1.150	1.220	1.280	1.340	1.400	1.460	1.520	1.580	1.640	1.700
3	1.730	1.760	1.790	1.820	1.850	1.880	1.900	1.920	1.940	1.960	1.980	2.000
4	2.030	2.067	2.100	2.133	2.167	2.200	2.233	2.267	2.300	2.333	2.367	2.400
5	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400

Example: An insured who has a third year claims-made policy and decides to cancel after three months have elapsed would purchase tail coverage at the year 3, three month factor (1.790), times the mature claims-made annual rate in effect at policy issuance. For claims-made year 5 and over the 2.400 factor applies.



## II. STATE REQUIREMENTS

### A. Policy Issuance

1. The Illinois State Law Endorsement must be attached to the policy at the time of issuance.
2. Item III, Quarterly Installment Options, is hereby added to Section 1, Introduction, as follows:

### III. QUARTERLY INSTALLMENT OPTIONS

1. Quarterly Installment Option One – (40/20/20/20)
  - a. A minimum initial deposit required, which shall be 40 percent of the estimated total premium due at policy inception;
  - b. The remaining premium spread equally among the second, third and fourth installments at 20 percent of the estimated total premium, and due 3, 6 and 9 months from policy inception, respectively;
  - c. No interest or installment charges;
  - d. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to the policy shall be billed immediately as a separate transaction; and
  - e. The installment plan will be limited to insureds whose premium exceeds \$500.00 per year.
2. Quarterly Installment Option Two – (35/25/25/15)
  - a. A minimum initial deposit required, which shall be 35 percent of the estimated total premium due at policy inception;
  - b. The remaining premium will be 25 percent for the second and third installments and 15 percent for the fourth installment, and due 3, 6 and 9 months from policy inception, respectively;
  - c. No interest or installment charges;
  - d. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to the policy shall be billed immediately as a separate transaction; and
  - e. The installment plan will be limited to insureds whose premium exceeds \$500.00 per year.

### B. Rules

